Task Force on Improving the Arizona Mental Health System

Final Report

November 30, 1999

Accession number: LSC99_13

TASK FORCE ON IMPROVING THE ARIZONA MENTAL HEALTH SYSTEM

FINAL REPORT

November 30, 1999

Members

James M. Bush, Chairman
Senator Sue Grace
Senator Tom Smith
Senator Ruth Solomon
Representative Sue Gerard
Representative Jeff Hatch-Miller
Representative Rebecca Rios
Alan J. Gelenberg, M.D.
Jack Harvey
Brian McNeil
Mike Meyer
Maurice Miller
Warren Rustand

3003 North Central Avenue
Suite 2600
Phoenix, Arizona 85012
602 916-5329
602 916-5529 fax

CHARGE TO THE TASK FORCE

Legislation (HB 2477) enacted by the Forty-fourth Legislature created a Mental Health Task Force and directed it to review and make recommendations to improve the current mental health system in a cost effective manner to include the following items:

1. The existing Arizona state hospital and any new facility, including requirements for the civil, forensic, juvenile and sexually violent persons populations.

2. Alternative housing for system members.

3. Expanded use of psychotropic medications.

4. Use of cost sharing between members in the system and the government.

5. Resolution of jurisdictional issues.

HEARINGS AND PRESENTATIONS

A. The Task Force has met on twelve separate occasions between August 18 and November 30, 1999 for a total of approximately thirty-six hours. The Task Force has heard presentations at more than one Task Force meeting from the following:

1. Jack Silver, Chief Executive Officer, Arizona State Hospital

2. Ron Smith, Director of Division of Behavioral Health (BHS), Department of Health Services (DHS)

3. Michael Franczak, Ph.D., Chief Bureau, Persons with Serious Mental Illness, Division of Behavioral Health, Arizona Department of Health Services

4. Wayne Hochstrasser, President/CEO, Triple R Behavioral Health, Inc.

5. Raymond L. Grey, C.I.S.W., Executive Director, Toby House, Inc.

6. Linda Glenn, Court Monitor, *Arnold v. Sarn*

7. Dr. Michael Zent, Chief Executive Officer, Value Options

B. The Task Force has heard presentations at one Task Force meeting from the following:

1. Ann Ronan, Attorney for Plaintiff, *Arnold v. Sarn*

2. Dan Steffey, Program Coordinator, Mental Health Association of Arizona, Tucson

APPENDIX MATERIAL

TABLE OF CONTENTS
AND
ATTACHMENTS AND APPENDIX MATERIAL

ATTACHMENTS TO REPORT

3. Michael Puthoff, President/Chief Executive Officer, The EXCEL Group, Yuma

4. Gene Messer, Chief Operations Officer, Arizona State Hospital (ASH)

5. Jan Brewer, Supervisor Maricopa County, Dr. Jack Potts, Judge Mike Jones, Superior Court, Maricopa County

6. Alan Ecker, Legislative Liaison, Nancy Hughes, Deputy Director, Dr. Pondolfino, Lead Psychiatrist at Florence, Eyeman Facility, Department of Corrections

7. Donna Hamm, Middle Ground

8. Members of the public representing family members

9. Charles McCoy and Frank Schweller representing Mental Health Advocates Coalition

10. Dr. Carol A. Lockhart, Health Systems Relations consultant

11. Susan Svitak, Maricopa County Correctional Health

12. Dr. Max Dine, representing himself

13. Kenneth Mounkes, Arizona State Hospital Advisory Board

14. Patricia Hamilton, representing herself.

15. Jowl DeVoskin, Consultant

16. John Wall, Director Central Arizona Shelter Services

17. Victor Hudenko, State Homeless Coordinator, Department of Economic Security

18. Russell Kolsrud, Attorney for Value Options

19. Paul Harris, Department of Commerce

20. Sharon Shore, CEO, Homes Inc.

21. Ted Williams, Former Director of Department of Health Services and currently Director of Arizona Behavioral Health Services

22. Jack Beveridge, Pinal-Gila RBHA

23. Robert Teel, Assistant Director, General Services Division, Department of Administration

24. Tim Brand, General Manager, Building & Planning Services Section, Department of Administration

25. Young B. Lee, Ph.D., representing himself

26. Kenneth Mounkes, representing himself

C. In addition to oral testimony, Task Force members have been furnished hundreds of pages of documentary material relating to:

1. The case of *Arnold v. Sarn*, including the pertinent provisions of the Judgment, Orders, Implementation Plan, Exit Agreement, Arizona Service Capacity Planning Project aka the Gap Analysis or Leff Report, and various appendices pertaining to the aforesaid documents and Orders including those pertaining to Housing, Employment Services and Vocational and Rehabilitational Matters which have been approved by the Court along with reports of the Court Monitor with respect to supervisory care homes.

2. Performance Audits of the State Hospital and Division of Behavioral Health by the State Auditor.

3. Proposed Plans for additions to the Arizona State Hospital by Mr. Silver and ASH Advisory Board.

4. The ASH Sexually Violent Persons Long Term Housing Options Team Report.

5. Descriptions and outlines of programs and housing facilities operated by Triple R Foundation and Toby House for persons with serious mental illness in Maricopa County.

6. An Outline of the RBHA program operated by Value Options in Maricopa County.

7. The ADHS/BHS FY 2001 Budget Request for Persons with Serious Mental Illness (copy attached to this Report as Appendix A).

8. The Maricopa County program for persons with serious mental illness including the County criminal justice program as it relates to persons with serious mental illness, together with the County's response to written questions presented to the County by the Task Force Staff.

9. Numerous Research Papers and articles by Mental Health Authorities dealing with the delivery of services or failure to deliver services to persons with severe mental illness including an article by Dr. Lockhart on "The New Psychotropics" An Assessment of Value and Cost in Arizona. (A summary of Dr. Lockhart's article

was presented orally to the Task Force and a copy is attached to this Report as Appendix C.)

10. A proposed Mental Health Services Delivery Program from the State of Wisconsin entitled "PACT Model".

11. Descriptions of housing options provided by Maricopa County providers Triple R Foundation and Toby House.

RECOMMENDTIONS TO IMPROVE THE CURRENT MENTAL HEALTH SYSTEM IN A COST EFFECTIVE MANNER

An effective mental health system is repeatedly defined by experts as one involving a "continuum of care". A system that extends from initial diagnosis through short term crisis treatment, hospitalization, medication, a residential treatment program that includes housing, treatment, vocational and rehabilitation services and jail diversion programs.

I. ARIZONA STATE HOSPITAL — FINDINGS AND RECOMMENDATIONS

A. Location and Utilization of Facilities

1. The 92 acres of land upon which the Arizona State Hospital is situated was conveyed by Maricopa County to the Territory of Arizona in 1885 for the specific purpose of operating a hospital for people with mental illness.

2. In 1965 the Arizona Supreme Court held that the conveyance from the County created a charitable trust with the beneficiaries being the mentally ill of the State.

3. Any attempt to relocate the hospital facilities on other land or to utilize the land for purposes other than a mental hospital would be inconsistent with and a violation of the trust.

4. It is the judgment of the Task Force that utilization of the ASH land and facilities for the care and treatment of persons with serious mental illness or who have been referred there from the criminal justice system because they have been determined to be either (i) guilty but insane; or (ii) mentally incompetent to stand trial are all uses consistent with the terms of the charitable trust.

5. It is the judgment of the Task Force that the utilization of ASH property and facilities by the Department of Corrections as a receiving center for persons convicted of crimes is inconsistent with the purpose of the charitable trust and should be terminated.

6. While the Task Force acknowledges that individuals civilly committed to the Sexually Violent Persons (SVP) program have some sort of personality or character disorder, the SVPs have not been diagnosed with a type of serious mental illness that requires the inpatient hospitalization and treatment normally offered at ASH. The presence of the SVP program at ASH seems more a reflection of financial and programmatic expedience rather than a good fit with the historical use and purpose of the ASH facility. The Task Force does not take issue with the SVP program itself. It is the judgment of the Task Force, however, that any housing of SVPs should be clearly separate and distinct from the civilly committed patients in accordance with the recommendations of Paragraph C of this Report.

B. <u>Bed Capacity For Non-Forensic Patients at ASH</u>

1. It is the judgment of the Task Force that the hospitalization at ASH for a non-forensic patient should be determined clinically on a case-by-case basis and should not be limited by some pre-determined and arbitrary cap that has no statutory support. The Task Force believes that the 55 bed limit for non-forensic patients from Maricopa County in Paragraph 10 of the Exit Criteria Order in *Arnold v. Sarn* is highly inappropriate, and we urge the plaintiff and defendants to seek an amendment deleting such provision from the Exit Criteria Order.

2. The task of estimating what should be the approximate size of a civil or non-forensic hospital is a policy matter to be determined by the Executive Branch and Legislative Branch and subject to change from time to time based upon population, the prevalence rate of seriously mentally ill people in the population and the adequacy of community residential treatment programs.

C. <u>The long term housing of sexually violent persons (SVP)</u>

1. The Task Force recommends that the Department of Corrections (DOC) occupancy of facilities at ASH be terminated at the earliest opportunity, and that upon vacation of the Alhambra facility by DOC, those facilities be made available and suitable for housing for the SVP program. The Task Force further recommends that any long term utilization on the east half of ASH property for SVPs should be restricted in terms of the total number of SVPs that can be detained and/or treated onsite. The Task Force further recommends that — following the adoption of an SVP-related census cap for the ASH campus — such cap should be adhered to without exception.

2. The Task Force has previously indicated its support for an approximate 4 million dollar facility for SVPs adjacent to the existing Cholla facility. This support was given because of the urgency of immediate need and not as acceptable permanent housing for the SVP program. Upon the termination of the DOC occupancy of

Alhambra, the SVP occupancy of Cholla and adjacent facilities should be vacated and transferred to Alhambra.

3. The Task Force believes that the west half of the 92 acre ASH facility should be used exclusively for a civil hospital and facilities, including any expansion, and the east half should be used exclusively for the forensic and SVP populations.

D. **The ASH Proposal For A New Civil Hospital, An Adolescent Facility And A Forensic Facility At The ASH location**

1. The Task Force supports the immediate construction of a new civil facility to be located on the northwest portion of the property with a separate entrance on 24th Street.

2. The ASH proposal submitted to the Task Force on November 9, 1999 calls for the construction of a new 200 bed facility and the renovation of a 200 bed forensic facility to be commenced in 2000. A potential additional 100 bed expansion of the civil facility and a potential 100 bed renovation for the forensic patients could commence, if necessary, in 2003 to 2006. The cost of these facilities are estimated to be $64 million. The ASH proposal also envisions a cost of $12 million for additional SVP facilities. The adequacy of this new civil facility and expansion according to Mr. Jack Silver, CEO of ASH, is predicated upon the implementation of an *adequate* community residential treatment program called for in the Judgment and Post-Appeal Orders of *Arnold v. Sarn*. The ADHS-DBHS proposed 2001 Budget presented to the Task Force, however, envisions a three year implementation plan for that program. (See Appendix A and B for ASH proposal)

3. Testimony presented to the Task Force by Value Options (Appendix A) and Department of Commerce and Department of Health Services (Appendix B) shows the following:

> "The demand for housing for consumers with serious mental illness vastly exceeds the supply. With the loss of HUD controls, current resources are shrinking."

4. Given the existing shortage of housing options, the potential loss of HUD funding plus a projected three year implementation plan — with a possible even longer implementation period — it is questionable whether a proposed 200 bed capacity civil hospital meets the test of adequacy.

5. The Task Force does not believe it is within its province to recommend exact size, design or structure of a new facility, but it does believe that any plan should allow for a new facility that would provide a capacity significantly larger than 200 beds in the absence of some firm

commitment or plan to effect a timely implementation of a Court ordered *adequate* residential treatment program.

E. Financing a New Civil Hospital Facility

1. The Task Force is aware that some portion of tobacco settlement money is being considered as a source of funding for a new hospital. The Task Force acknowledges that it was not a subject of its charge to recommend how a new facility should be funded. Nevertheless, the Task Force — most respectfully — requests that consideration be given to the possible use of private funding as one option for the construction of a new hospital facility.

2. Mr. Robert Teel and Mr. Tim Brand of the Department of Administration presented to the Task Force, the Department's latest thinking, and practice, in regard to office space for employees and the relative costs between lease/purchase and State financed construction. A long-term lease with the option to purchase, at any time during, or on expiration of the lease, could present the State an alternate funding measure that may be worthy of further consideration in developing an adequate total mental health program. (See Appendix C)

II. Alternative Housing For System Members

A. Findings

Article 10, Title 36 of Arizona Revised Statutes is entitled Community Mental Health Residential Treatment System and covers A.R.S. § 36-550 through 550.08. The "Legislative Findings" and "Legislative Intent" found in Article 10 state inter alia, as follows:

> "1. There is a growing and vulnerable population of chronically mentally ill persons for whom hospitalization or institutionalization is not appropriate."
>
> . . .
>
> "2. The existing mental health system does not provide sufficient rehabilitative programs for these people that would enable them to remain in the community and function at their optimal level."
>
> "It is the Legislative intent to:
>
> 1. Provide a statewide system of residential service and adequate treatment for the chronically mentally ill

in the least restrictive alternative available and in accordance with the client's needs."

"4. Provide state funds to facilitate the development of community residential treatment systems for the chronically mentally ill at the county level."

B. *ARNOLD V. SARN*

1. The Trial Court - 1981

This suit was filed as a class action in 1981 to enforce the provisions of the aforementioned Community Mental Health Residential Treatment System on behalf of the seriously mentally ill in Maricopa County. The Trial Court entered Judgment in 1986 and the following are pertinent excerpts from the Conclusions of Law in the Court's January 7th Order:

"2. There is an entire statutory scheme in which the Arizona Legislature has mandated that the Arizona Department of Health Services has primary responsibility in providing mental health services to all class members, including the named plaintiffs ('plaintiff class').

3. The Department of Health Services has mandatory, non-discretionary duties under A.R.S. §§ 36-102, -104.1(c), - 104.5, -104.16, -104.17 and 36-550 to provide the plaintiff class with an adequate system of community mental health services.

9. A.R.S. § 36-104.16 requires the director to provide a wide range of community residential programs and services to the plaintiff class as alternatives to more costly institutional care.

10. Under the statutory scheme, the Department is mandated to provide a full continuum of care for all class members including, but not limited to: inpatient care, case management, residential services, day treatment, outreach, mediations, outpatient counseling, crisis stabilization, mobile crisis services, socialization, recreation, work adjustment and transportation.

13. The Department of Health Services has breached its mandatory non-discretionary duties under A.R.S. § 36-102, -104.1(c) and -104.5 to provide a unified and coordinated mental health system for the plaintiff case.

15. The Department of Health Services has breached its duties under A.R.S. § 36-550.01 to provide community residential services. Only a small percentage of the chronically mentally ill individuals in Maricopa County are receiving these mental health services mandated by the Legislature.

19. The Arizona State Hospital has a mandatory non-discretionary duty pursuant to A.R.S. § 36-511.C to ensure that discharged patients have a place to live and an adequate program for necessary treatment and maintenance and to effectuate the plans." (emphasis added)

2. **The Arizona Supreme Court in *Arnold v. Arizona Department of Health Services*, 775 P.2d 521 - 1989**

The Arizona Supreme Court in 1989 affirmed the Judgment of the Trial Court holding that the State had breached its statutory duty by failing to provide an "adequate" system. In the conclusion to its Opinion, the Court stated as follows:

"It has been stated that '[t]he moral test of government is how it treats those who are in the dawn of life, the children; those who are in the twilight of life, the aged; and those who are in the shadows of life, the sick, the needy and the handicapped.' Arizona has imprisoned its CMI in the shadows of public apathy. The legislature was the first to speak on the issues before us. *We find no evidence in this record that the legislature intended to pass sham legislation.* The legislature thoroughly, carefully and completely mandated duties of the state and county to the CMI population in Arizona. We hold that the legislature has mandated that the state and the county have a duty to jointly and harmoniously provide mental health care to the plaintiff class. *In so holding we note that the duty may well be more expensive in the breach than in the fulfillment.*" (emphasis supplied)

3. **Trial Court — 1991 to date**

Post Appeal Orders: Implementation Plan aka *Blueprint* (May, 1991) *and* Stipulation for Exit Criteria and Disengagement (13 November, 1995)

a. There may be a perception in the minds of some that the Plan for implementing the decision in *Arnold v. Sam* originated with the Court. That is not the case.

The *"Implementation Plan" or Blueprint* originated with and was negotiated between the State, Maricopa County, and the plaintiffs. It was approved by the Court in May of 1991.

b. In 1995, the State acknowledged that it had failed to meet the Blueprint obligations. The Parties then entered into a substitute agreement approved by the Court entitled *"Stipulation for Exit Criteria and Disengagement."*

4. **ARIZONA SERVICE CAPACITY PLANNING PROJECT AKA "THE LEFF REPORT" OR "GAP ANALYSIS" BY HUMAN SERVICES RESEARCH INSTITUTE (HSRI)**

On December 22, 1998 after a hearing on an allegation of defendant's non-compliance with the Exit Criteria Stipulation, the Court approved a Supplemental Agreement in *Arnold v. Sarn* for ADBHS to retain HSRI to determine the type, intensity and amount of services necessary to meet the individual need of class members and to create a service capacity attachment to identify the need, service and costs. A copy of the HSRI Report is Appendix H to this Report and has an adjusted cost for Maricopa County of $317 million dollars.

5. **THE ADHS/DBHS PROPOSED FYE 2001 BUDGET FOR IMPLEMENTING THE HSRI STUDY FOR THE STATEWIDE POPULATION OF SERIOUSLY MENTALLY ILL PERSONS.**

The ADHS/DBHS estimate of the statewide cost for services under the HSRI Study is $528 million dollars. Current expenditures for services and medications approximate $172 million leaving a shortfall of approximately $356 million. The Budget proposal requests that the shortfall of $356 million be phased in over three years. For the FYE 2001, DBHS seeks 127.5 million for services to fund those people with serious mental illness who have been designated as "priority" under the *"Exit Criteria Stipulation"*. Of the seriously mentally ill population, approximately 50% are eligible for benefits under Title XIX (Medicaid). Of the 127.5 million for services, $34.4 million would be federal funds.

A copy of the ADHS/DBHS FYE 2001 proposed Budget is Attachment No. 1 to this Report. Attachment No. 2 to this Report is a Summary prepared by DBHS for the Task Force showing by category of service the funding allocation for all services and medications of $313 million for the entire SMI population after adding the proposed $127.5 million for "priority" clients.

RECOMMENDATIONS

A. THE TASK FORCE SUPPORTS THE DBHS BUDGET PROPOSAL FOR THE FOLLOWING REASONS

1. Since 1981, there has been a failure to provide adequate funding for the *"Community Residential Treatment Program"* determined by the Supreme Court to be a mandatory obligation.

2. The State, Maricopa County, the plaintiffs and the Court Monitor have jointly agreed to the required provisions of an *adequate* program. The HSRI Report provides an estimate of the costs for providing the services for such a program. (See Attachment 3 for the Executive Summary of the HSRI Report)

3. Neither the data, the methodology used, nor the conclusions reached in the HSRI Report were challenged by plaintiff or defendants in court proceedings, nor has any challenge been made to the Report in hearings before the Task Force. (See Attachment 4 for DBHS Statement to the Task Force expressing its concurrence with the HSRI Report and stating "that it's conclusions represent a reliable estimate of what is required in order to have the opportunity to meet the State's requirements.")

4. The three year phase-in for funding, and the sum of $127.5 million for priority clients contained in the proposed FYE 2001 budget have been agreed to by DBHS, the plaintiffs and the Court Monitor.

   Testimony presented to the Task Force discloses that the lack of housing is probably the most serious obstacle to providing needed treatment and other services to people with a serious mental illness. As previously stated in this Report, the Arizona Department of Commerce, DBHS and Value Options have stated that:

   > "The demand for housing for consumers with serious mental illnesses vastly exceeds the supply. With the loss of HUD controls, current resources are shrinking."

   In 2000, HUD funding for 559 housing units for people with a serious mental illness will expire; 329 additional units will expire in 2001, and there is a significant likelihood that not all of the units will get refunded. (See Appendix F and G)

   Apart from persons identified as "homeless" or who are clients being served by Value Options and living in *acceptable alternative housing*, there are hundreds of other seriously mentally ill persons living in "supervisory care" facilities that are *not considered to be acceptable "alternative housing"*. (See Appendix K and L)

5. The FYE 2001 Budget proposal includes approximately $58 million for housing. *Failure* to implement the FYE 2001 proposal and proposed three

year *"phase in"* may render the ASH proposed 200 bed hospital — *"Inadequate"*.

6. The alternatives to an *"inadequate"* state hospital along with an *"inadequate"* community residential treatment program are painfully predictable:

   a. A greater tendency for the seriously mentally ill person to decompensate and potential unwillingness to follow through with medication;

   b. A tendency for many to wander aimlessly in the community unable to manage their psychotic impulses;

   c. A virtual certain involvement by some in the criminal justice system with the attendant expenses and tragic consequences connected with it. (See Appendix M, Complaint by *Estate of Marilyn Brower, et. al v. State of Arizona, et. al.* Also Appendix J-1 and J-2 where Maricopa County states that from 7 to 10% of the prisoners in the County Jail are assessed as mentally ill.)

   d. And, finally, as the Arizona Supreme Court indicated in its Opinion — a failure to fund an adequate program may expose the State to a greater cost than the cost of complying with the statute.

7. Fulfilling the Budget Proposal and implementing the service program is not only the right thing to do, it demonstrates the state's commitment to bring the *Arnold v. Sarn* litigation to a close and establish that Article 10 of Title 36 A.R.S. is not "sham legislation".

B. The Task Force further recommends that ADHS, in connection with any Phase II or Phase III requests — prepare clear and specific budget implementation plans together with appropriate systems for the ongoing monitoring of plan effectiveness.

III. EXPANDED USE OF PSYCHOTROPIC MEDICATIONS

The 1999 Budget of DBHS contained an increase for the use of psychotropic medication, and the FYE 2001 Proposed Budget provides $16.2 million for medications. The Task Force supports the proposed increase and expanded use of psychotropic medication for all the SMI population. Dr. Carol Lochart presented testimony to the Task Force, and a copy of her presentation is Attachment 5 to this Report.

IV. USE OF COST SHARING BETWEEN MEMBERS IN THE SYSTEM AND GOVERNMENT

The ADHS/DBHS Policy for co-payments by persons receiving services is entitled: Administrative and Program Support Services, and is set forth in Chapter 2 of

the Policy and Procedures Manual, a copy of which is Attachment 6 to this Report. Pertinent excerpts from the Policy are as follows:

1. "When meeting the financial criteria, clients will be assessed a co-payment for services to assist in paying the cost for their care. Such assessments shall be based on information collected from the client, and shall take into account the client's ability to pay. No client shall be denied services due to an inability to pay for their care."

* * * *

2. "With the exception of residential programs for adults with behavioral health problems, RBHAs and their providers utilize the Client Co-Payment Schedule: Services to determine the amount of the client's co-payment for services (Attachment B). For residential programs, the amount of rent a client must pay shall be determined in accordance with the ADHS/BHS policy Tenant Rent, Rent Reasonableness and Affordability. Services may be billed for in addition to the housing costs. In all cases, clients in residential programs shall have at least $60.00 of income remaining for personal use after co-payments for services and rent are deducted from their income."

3. "Co-payment policies include the following provisions:

   "(1) RBHAs and their providers do not assess co-payments for services that are reimbursable by Title XIX if the client is Title XIX eligible and enrolled with a RBHA."

   "(2) Co-payments may be assessed for non-Title XIX reimbursable services provided for Title XIX enrolled individuals."

With respect to HUD supported housing, federal rules provide that rental charges may not exceed 30% of the person's monthly income.

Providers who have appeared before the Task Force testified that housing charges are imposed upon their respective clients, and that it varies with ability to pay

The Task Force supports the co-pay policy of ADHS/DBHS.

V. Cost Sharing of Mental Health Services Between the State and Counties

Findings and Recommendations

A. It is clear from the Supreme Court decision in *Arnold v. Sam* that the State and Counties both have an obligation to provide services to the seriously

mentally ill. The Trial Court has ruled that the costs between the State and Maricopa County should be shared equally.

B. A.R.S. § 36-550.05, subsection A.2. provides that ADHS may "contract with individual counties to provide programs or services directly or by contract with other public or private agencies" and subsection B or A.R.S. § 36-550.05 provides: "If the deputy director contracts with a county as prescribed in subsection A of this section, the deputy director may require not more than twenty-five percent match of local or other funds."

C. Currently, only two counties (Maricopa and Pima) have Intergovernmental Agreements (IGAs) with the State requiring cost-sharing but in vastly different amounts and different formulas. The other thirteen counties do not have any cost-sharing IGAs with the State, but they do receive funds or services from the State for the care of indigent people in their counties suffering from serious mental illness.

D. The Task Force recommends that the Legislature consider and determine how the required funding for mandated community residential treatment programs for the seriously mentally ill throughout the State should be borne between the State and counties. That is: Should such funding be the sole obligation of the State? Should the costs for the mandated programs be shared between the State and counties? If cost-sharing is determined to be appropriate, should the formula for cost-sharing be uniform for all counties (50-50 as determined by the Court in *Arnold v. Sarn*) or at some lesser figure that may be applicable under A.R.S. § 35-550.03 A.2? Or lastly, if cost-sharing is determined to be appropriate should each county's obligation be treated differently?

E. Finally, Upon a resolution and determination of the cost-sharing issue appropriate amendments if any should be made to A.R.S. § 35-550.03 A.2., including any new formulas to be used for cost-sharing.

VI. RESOLUTION OF JURISDICTIONAL ISSUE

If this topic was really intended to be a "Question" — then, it appears that the "Question" is: When does the Court's jurisdiction end?

A. The answer to that "Question" lies in the "Stipulation on Exit Criteria and Disengagement" which the State, County and Plaintiffs voluntarily negotiated and agreed to. The provisions of the Stipulation provide an answer to that "Question" as follows:

"2. This Stipulation on Exit Criteria and Disengagement defines the actions and requirements which the defendants must complete and the services, supports, and benefits which must be provided to

classmembers in order for the defendants to fully satisfy their obligations to classmembers under the Court's Judgment and the Arizona Supreme Court's opinion in this case."

"3. Except where a different standard is explicitly set forth in a particular paragraph herein and consistent with the provisions of ¶ 53 of this Stipulation, the defendants will make reasonable progress in implementing the provisions of the Stipulation on Exit Criteria and Disengagement. The parties further agree that compliance with specific provisions of this Stipulation will result in partial satisfaction of the Judgment and that compliance by both of the defendants with all of these actions and requirements set forth in this Stipulation will result in full and final satisfaction of the Judgment in this lawsuit."

* * * *

"10. In order to serve a significant portion of these classmembers in the community, ADHS will make available and maintain community living arrangement plus appropriate supports necessary to meet the individual needs and to ensure the appropriate discharge of classmembers at ASH, as set forth in ¶ 29. For the term of this Stipulation, ADHS will ensure that the level of resources which fund these community living arrangements and appropriate supports will be used almost exclusively for classmembers who move from ASH or supervisory care homes."

* * * * *

"33. The annual budget requests of the director of ADHS to the Governor during the term of this Stipulation *shall be sufficient to maintain the level of state funding which supports services for classmembers in Maricopa County as of July 1, 1994, as well as to fund the service development and other requirements of this Stipulation.* (emphasis supplied)

The Director of ADHS shall use best efforts to ensure that the Governor fully adopts the agency's budget request for community services for individuals with serious mental illness in the executive budget to the Legislature. The Director will, as part of the Department's annual written budget request in accordance with Arizona law, provide the Legislature with the amount and rationale of ADHS' budget request to the Governor, including why that level of funding is necessary to continue existing services and to develop the new community services required by this Stipulation, and will respond to legislative inquiries."

B. The ADHS/BHS Budget Request for FYE 6/30/2001 for Persons with a Serious Mental Illness was approved by the Court Monitor as Phase One of three steps to implement the Judgment in *Arnold v. Sarn*. Approval of that Budget and its implementation will result in partial satisfaction of the Judgment and to that extent a "resolution of some jurisdictional issues."

CONCLUSION

With medical sciences on the cusp of new breakthroughs in the diagnosis and treatment of mental illness, Arizona is well positioned to become a leader in mental health research and treatment. Recognizing both the significant commitment the State has made to meet the needs of the seriously mentally ill, together with the need for research in this area, the Task Force recommends that the Governor and the Legislature give consideration to the establishment of a Mental Health Research Institute with a mission to discover causes, to predict and prevent, and find new treatments for mental illness. In furtherance of such a goal a technically qualified Task Force could work with ADHS and the University of Arizona College of Medicine to consider the viability of such a project. It is the view of this Task Force that such a project should be one in which the State and the private sector would both participate.

Respectfully Submitted,

James M. Bush

James M. Bush, Chairman

ATTACHMENT No. 1

Final Report - Mental Health Task Force
November 30, 1999

Arizona Department of Health Services/Behavioral Health Services

FYE 6/30/2001 Budget Request
Persons with a Serious Mental Illness

FYE 2001 Budget Overview

Background

- Based upon Human Services Research Institute (HSRI) Study of Maricopa County:
  - ADHS/BHS requires $317 million for a comprehensive, full capacity mental health system within Maricopa County, as established by the Exit Stipulation criteria of Arnold v ADHS.
  - Results of Maricopa County study will be extrapolated to the entire State.

FYE 2001 Budget Overview

Assumptions

- Maricopa County accounts for approximately 60% of the State-wide population.
- Approximately 50% of persons with a serious mental illness are Title XIX eligible.
- State-wide the total dollar requirement is approximately $528,000,000.

FYE 2001 Budget Overview

Priority Persons (continued)

- "Other Priority" means persons who are:
  - frequent crisis or inpatient care users; or
  - need 24 hour residential services; or
  - are in jail with a major biological disorder.
  - According to the Exit Stipulation, ADHS must meet 80% of their needs.
  - There are approximately 1,432 other priority persons in Maricopa County.

FYE 2001 Budget Overview

- By funding the full array of service to "Priority" Persons ADHS/BHS also begins implementation of the Strategic Plans of the Exit Stipulation:
  - Employment/vocational services
  - Residential/housing services
  - Dual diagnosis services
  - Assertive Community Treatment teams (ACT) & other intensive clinical services

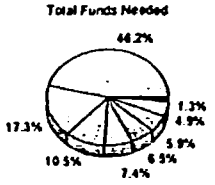
FYE 2001 Budget Overview

Request

- The budget request for persons with serious mental illness is broken into two components:
  - Services
  - Medications

FYE 2001 Budget Overview

Service Category Percentage



- [ ] Residential
- [ ] Rehabilitation
- [ ] Treatment Support Services
- [ ] Administration
- [ ] Hospital
- [ ] Emergency
- [ ] Outpatient Treatment
- [x] Other Support Services

FYE 2001 Budget Overview

Service Categories

- Residential Services
  - Group homes or in-home supervision
    - High intensity (4 bed/24-hour professional supervision)
    - Moderate (8 bed/24-hour paraprofesional supervision)
    - Low/minimum (SIL, overnight and on-call supervision)
  - Independent Living/Housing Subsidy
  - Specialized Residential
    - Dual diagnosis
    - Medical needs
    - Geriatric

FYE 2001 Budget Overview

Residential

RESIDENTIAL	Gross Dollars	Beds
Intensive Staff Supervision	[illegible]	[illegible]
Specialized Residential/Dual Diagnosis	[illegible]	[illegible]
Moderate Staff Supervision	[illegible]	[illegible]
Minimum Staff Supervision	[illegible]	[illegible]
Subtotal of Supervised Beds/Slots	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
Indep. Living w/ Subsidized Housing	[illegible]	[illegible]
Indep. Living w/o Subsidized Housing	[illegible]	[illegible]
Subtotal	[illegible]	[illegible]

FYE 2001 Budget Overview

Hospital

HOSPITAL	Dollars
Inpatient Specialty Staff	[illegible]
Inpatient [illegible]	[illegible]
Inpatient [illegible]	[illegible]
Inpatient [illegible]	[illegible]
Inpatient Detox	19,200
SUBTOTAL	8,256,174

FYE 2001 Budget Overview

Service Categories

- Outpatient Treatment
  - Professional services/evaluation & management
  - Court Ordered Evaluation
  - Psychotherapy (individual, group, family)
  - Therapeutic supervision
  - Outpatient detoxification
  - Substance abuse counseling
  - Methadone maintenance

FYE 2001 Budget Overview

Outpatient Treatment

Outpatient Treatment	Dollars
Professional/Evaluation & Management	169,190
Court Ordered Evaluation	[illegible]
Individual Psycho-Therapy	[illegible]
Group Psycho-Therapy	[illegible]
Family Psycho-Therapy	[illegible]
Therapeutic Supervision	[illegible]
Outpatient Detox	[illegible]
Substance Abuse Counseling	[illegible]
Methadone Maintenance	[illegible]
SUBTOTAL	[illegible]

FYE 2001 Budget Overview

Treatment Support Services

Treatment Support Services	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
SUBTOTAL	[illegible]

FYE 2001 Budget Overview

Service Categories

- Other support services
  - Protection & advocacy
  - Transportation
  - Family education & support
  - Friend advocacy/peer support

FYE 2001 Budget Overview

Other Support Services

Other Support Services	[illegible] Dollars
Protection & Advocacy	[illegible]210,651
Client Transportation	[illegible]265,123
Family Education & Support	[illegible]813,930
Friend Advocacy/Peer Support	[illegible]365,846
SUBTOTAL	[illegible]675,551

FYE 2001 Budget Overview

Request Overview

Services

Title XIX Services	$34.4 million Federal Funds
Title XIX Services	$18.5 million State Funds
Non-Title XIX Services	$74.6 million State Funds

Medications

Atypicals	$4.1 million State Funds
All Other Meds	$9.5 million State Funds

Total Federal Funds	$34.4 million
Total State Funds	$106.7 million

Housing

Current Housing in Maricopa County

- Nearly 2657 consumers receive housing assistance.
- However, there are few housing options available.
- Almost 900 of these units are HUD funded.

Existing HUD Housing Programs for Maricopa County

Type of Program	# of Units	Grant Recipient	Annual Cost	Expiration Date
S+C	143	ADOC	$ 913,500	June 2000
S+C	280	ADOC	$ 1,800,000	June 2000
S+C	200	ADOC	$ 1,301,900	June 2001
SHP (2 projects)	133	ADOC	$ 948,300	June 2001
SHP	06	ADOC	$ 145,000	Dec 2002
SHP (5 projects)	133	ABC	$ 2,631,865	2000
Total	895		$ 7,739,665	

- Continue to work with HUD to change statutory language regarding mandated 5-year refunding of Shelter Plus Care projects,
- Work closely with HUD and the Arizona Congressional delegation to shift the cost of Shelter Plus Care renewals from the Continuum of Care (competitive) account to the mainstream Section 8 (non-competitive) account.
- Work closely with HUD and the Arizona Congressional delegation to support the Administration's current budget request for 18,000 new incremental Section 8 vouchers for the homeless.

- Continue to work with Public Housing Authorities and affordable housing developers to set aside a % of affordable housing units for this population.
- Continue to work with the Legislature to develop funding sources for both existing housing units and for units to meet future housing needs of this population

Summary of the Information Prepared for the MENTAL HEALTH TASK FORCE By ADHS/DBHS

NOVEMBER 9, 1999 TASK FORCE MEETING

I. Analysis of current spending versus proposed spending for persons with a serious mental illness (SMI).

Please note that the current spending for the service categories of residential, treatment and support has changed from the report distributed October 26, 1999 Task Force meeting. All other amounts remain the same. The change is due to the fact that the Leff Report includes the treatment and support provided to persons in a residential setting in the residential category. The report distributed October 26 under current spending did not do this. Therefore, the attached analysis has moved the treatment and support costs provided to persons in a residential setting to the residential category. This more accurately compares the current behavioral health system to the Leff Report.

II. Analysis of funding requirements under the Leff Report: proposed ($313,162M), Exit Stipulation per the Leff Report ($528,314.2M), and the difference not requested at this time ($215,152.2M) due to an agreement to seek incremental funding.

III. Analysis of how $52.2M in funding would be shifted from the current "priority SMIs" to "all other SMIs" population if the $127.5M budget request is approved.

IV. Detail listing of specific services provided within each service category of the Leff Report.

V. Narrative of how a "priority" person's life will change should the proposed spending be approved.

PREPARED FOR THE MENTAL HEALTH TASK FORCE BY ADHS/DBHS
(ALL NUMBERS ARE IN 000'S)

SERVICE CATEGORY	CURRENT SPENDING BY CATEGORY OF SERVICE: PRIORITY SMI*	ALL OTHER SMI**	TOTAL FOR ALL SMI	
RESIDENTIAL	$25,728.3	$20,273.7	$46,002.0	
EMERGENCY SERVICES	2,925.5	4,511.6	7,437.0	
HOSPITAL	8,104.1	15,682.3	23,786.4	
TREATMENT	4,152.9	5,100.5	9,253.4	
REHABILITATION	2,228.9	2,449.5	4,678.4	
SUPPORT SERVICES	5,188.3	34,763.9	39,952.3	
SERVICES ADMINISTRATION	3,866.2	6,622.5	10,488.8	
TOTAL SERVICES	52,194.3	89,404.0	141,598.3	(1)
MEDICATIONS	11,248.6	19,153.1	30,401.7	(2)
TOTAL SERVICES & MEDS.	$63,442.9	$108,557.1	$172,000.0	(3)

SMI FUNDING BY REVENUE SOURCE	
TITLE XIX	$63,846.6
TITLE XXI	360.0
STATE APPROPRIATIONS	64,608.8
COMMUNITY PLACEMENT	7,848.0
FEDERAL BLOCK GRANTS	701.6
MARICOPA COUNTY IGA	23,637.3
ALL OTHER REVENUE	10,997.7
TOTAL ALL REVENUE	$172,000.0

PROPOSED FUNDING ALLOCATION OF $313.2M ($172M CURRENT APPROPRIATION PLUS REQUESTED $127.5M FOR SERVICES TO PRIORITY CLIENTS & $13.6M FOR MEDICATIONS TO ALL CLIENTS)

SERVICE CATEGORY	PRIORITY SMI*	ALL OTHER SMI**	TOTAL FOR ALL SMI	
RESIDENTIAL	$58,928.5	$36,678.9	$95,607.4	
EMERGENCY SERVICES	7,511.5	12,844.9	20,356.4	
HOSPITAL	8,256.2	15,682.3	23,938.5	
TREATMENT	6,242.7	5,100.5	11,343.2	
REHABILITATION	22,116.1	18,854.7	40,970.8	
SUPPORT SERVICES	15,038.1	41,948.2	56,986.3	
SERVICES ADMINISTRATION	9,447.4	10,488.8	19,936.2	
TOTAL SERVICES	127,540.4	141,598.3	269,138.7	(1)
MEDICATIONS	16,244.6	27,778.7	44,023.3	(2)
TOTAL SERVICES & MEDS.	$143,785.0	$169,377.0	$313,162.0	(3)

SMI FUNDING BY REVENUE SOURCE	
TITLE XIX	$116,690.5
TITLE XXI	360.0
STATE APPROPRIATIONS	152,926.9
COMMUNITY PLACEMENT	7,848.0
FEDERAL BLOCK GRANTS	701.6
MARICOPA COUNTY IGA	23,637.3
ALL OTHER REVENUE	10,997.7
TOTAL ALL REVENUE	$313,162.0

(1) The difference between the $141.6 million and the $269.1 million is the additional budget request for services of $127.5 million.

(2) The difference between the $30.4 million and the $44.0 million is the additional budget request for medications of $13.6 million.

(3) The difference between the $172.0 million and the $313.1 million is the total additional budget request for ALL SMI of $141.1 million.

*** Priority SMI are those who meet one of the following criteria:**
Have been in supervisory care homes
Have been residents of the Arizona State Hospital
Are in jail with a major biological disorder
Are frequent crisis or inpatient care users or need 24 hour care

**** All Other SMI are those who do not meet the above definition.**

PREPARED FOR THE MENTAL HEALTH TASK FORCE BY ADHS/DBHS
(ALL NUMBERS ARE IN 000'S)

SERVICE CATEGORY	TOTAL PROPOSED SPENDING FOR ALL SMI	EXIT STIPULATION FUNDING PER LEFF REPORT FOR ALL SMI	REMAINING NEEDED FUNDING TO FUND LEFF REPORT
RESIDENTIAL	$95,607.4	$224,299.3	$128,691.9
EMERGENCY SERVICES	20,356.4	27,736.8	7,380.4
HOSPITAL	23,938.5	25,578.6	1,640.1
TREATMENT	11,343.2	25,637.5	14,294.3
REHABILITATION	40,970.8	88,179.0	47,208.2
SUPPORT SERVICES	56,986.3	56,986.3	0.0
SERVICES ADMINISTRATION	19,936.2	35,873.4	15,937.2
TOTAL SERVICES	**269,138.7**	**484,290.9**	**215,152.2**
MEDICATIONS	44,023.3	44,023.3	0.0
TOTAL SERVICES & MEDS.	**$313,162.0**	**$528,314.2**	**$215,152.2**

PREPARED FOR THE MENTAL HEALTH TASK FORCE BY ADHS/DBHS
(ALL NUMBERS ARE IN 000'S)

In their budget request, ADHS/BHS requested $127.5M for services. This is the amount that would be needed to fully fund all services for the Priority SMI* population. If the department received the entire amount of the request, the amount that is currently being spent on the Priority SMI ($52.2M), would be shifted to fund services for All Other SMI**. This spreadsheet details how that shift in funding would be allocated among the different services.

SERVICE CATEGORY	CURRENT FUNDING ALL OTHER SMI	PROPOSED SPENDING ALL OTHER SMI	AMOUNT CURRENTLY SPENT ON PRIORITY SMI THAT WOULD BE AVAILABLE FOR "ALL OTHER" SMI
RESIDENTIAL	$20,273.7	$36,678.9	$16,405.2
EMERGENCY SERVICES	4,511.6	12,844.9	8,333.3
HOSPITAL	15,682.3	15,682.3	
TREATMENT	5,100.5	5,100.5	
REHABILITATION	2,449.5	18,854.7	16,405.2
SUPPORT SERVICES ***	34,763.9	41,948.2	7,184.3
SERVICES ADMINISTRATION	6,622.5	10,488.8	3,866.2
TOTAL SERVICES	89,404.0	141,598.3	$52,194.3

*** Priority SMI are those who meet one of the following criteria:**
Have been in supervisory care homes
Have been residents of the Arizona State Hospital
Are in jail with a major biological disorder
Are frequent crisis or inpatient care users or need 24 hour care

**** All Other SMI are those who do not meet the above definition.**

***** Includes fully funding ACT Teams.**

MENTAL HEALTH TASK FORCE REQUEST
SPECIFIC SERVICES WITHIN EACH SERVICE CATEGORY

RESIDENTIAL
Medical/Nursing/Professional Supervision
24 Hour Therapeutic Supervision/Personal Care
Structured Day Treatment Program
Individual, Group & Family Counseling
Psychiatric Rehabilitation/Skills Training
- independent living skills
- medication management skills
- interpersonal skills

Substance Abuse Treatment
Transportation
Recreation/Socialization
Room & Board
Independent Living Support
Rent Subsidy
Geriatric Services

EMERGENCY SERVICES
Mobile Crisis Teams
Urgent Care/Crisis Emergency Walk-In
Crisis Residential
Respite Care

HOSPITAL
Arizona State Hospital
Free-standing Psychiatric Hospitals
Psychiatric Unit of General Medical Hospital
Medical Detoxification

(OUTPATIENT) TREATMENT
Individual, Group and Family Counseling/Psychotherapy
Psychological Evaluation
Psychiatric Consultation, Evaluation and Management
Pre-Petition Screening and Court Ordered Evaluation
Personal Care/Therapeutic Supervision
Outpatient Detoxification.
Substance Abuse Treatment
Methadone Maintenance

REHABILITATION
Psychiatric Rehabilitation/Skills Training
- independent living skills
- medication management skills
- interpersonal skills

Consumer Operated Drop-In Center
Consumer Operated Clubhouse/Work Site
Vocational Assessment
Supported Employment
Support Education

SUPPORT
Assertive Community Treatment
Intensive Case Management
Clinical Team Services
Medication Management
Protection & Advocacy
Client Transportation
Family Education
Peer Advocacy

MENTAL HEALTH TASK FORCE REQUEST
HOW WILL MY LIFE CHANGE AS A PRIORITY PERSON WITH A SERIOUS MENTAL ILLNESS IF ADDITIONAL FUNDING IS APPROVED?

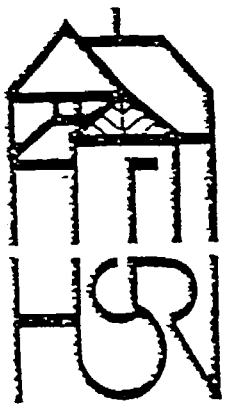
Service Category	*Current Situation*	*Situation if Additional Funding is Approved*
Residential	I depend on my family, or live indefinitely in an intensively staff supervised facility or minimally supervised and un-licensed supervisory care home.	I receive supportive services in an independent housing setting designed to teach me to live on my own or with a group of others of my choice.
Emergency Services	I am taken to the urgent care, or ER or by police when I relapse, after being off my medication for months.	Preventative crisis services are provided to assist my clinical team in supporting me at the very first sign of my becoming ill again or missing needed medications.
Hospital	No major change.	No major change.
Treatment	If I am "high functioning", I may receive individual counseling.	My family and I both receive education, training and treatment to recognize symptoms, control substance use and manage my own illness.
Rehabilitation	In the group home I live in, they remind me to brush my teeth and wash my clothes. Sometimes my case manager has time to teach me how to use the bus.	Learning to be self-sufficient is a major focus of my treatment. I receive skill-training and cognitive remediation to help me live independently, interact with others, and get and keep a real job.
Support Services	My case manager helped me to get this apartment, but I'm about to be evicted because I haven't paid the rent. When I have to be hospitalized, they drive me there.	When I am not doing well, my psychiatrist, nurse or case manager come to my house to be sure I am taking medication, taking physical care of myself, and keeping my rent up to date and my apartment clean.
Medications	If I am a new patient, or I am having bad side effects, or frequently in crisis or hospital or my family pressures the team, I may be put on a new medication. Otherwise, I take the same medication for years, even though I am not doing all that well.	Even though I didn't request it, or have any crisis episodes, my doctor discussed changing my medication, because I am functioning at a very low level, and haven't improved after six to eight weeks on this medication and dose.

ATTACHMENT No. 3

Final Report - Mental Health Task Force
November 30, 1999

EXECUTIVE SUMMARY FOR:

ARIZONA SERVICE CAPACITY PLANNING PROJECT



HUMAN SERVICES RESEARCH INSTITUTE

Executive Summary

This study of the mental health service needs of persons with serious mental illness in Maricopa County was commissioned by the Arizona Division of Behavioral Health Services (ADBHS) pursuant to the ongoing provisions of the *Arnold v Sarn* agreement and the direction of the Court Monitor. The objectives of the study were to estimate the types, amounts, and costs of mental health services needed by persons with serious mental illness in Maricopa County.

The study was conducted by the Human Services Research Institute (HSRI) in collaboration with the ADBHS and other parties involved in *Arnold v Sarn*. For the study, HSRI employed resource allocation planning methods used in over a dozen other states (Leff, 1998). These methods combine clinical expertise with statistical methods and computer implemented simulation technology developed in a collaboration between HSRI and colleagues at the Massachusetts Institute of Technology (Leff, Graves, Natkins, & Bryan 1985; Leff, Dada, & Graves 1986). HSRI used data on client functional status, service needs and outcomes, and service costs collected in Arizona and other states. As part of the planning process, the data from Arizona and other states was validated by checks for completeness and consistency. As needed, the data was adjusted to reflect particular features of the Arizona mental health system and current labor market conditions.

The model used by HSRI recognizes that many persons with serious mental illness can become independent and productive members of our community with the proper intensity of services for a limited period of time. Other individuals will require ongoing supports for an indefinite period. A very small number will require intensive services throughout their lives, usually because they have complicated combinations of disabling conditions. The model categorizes persons by different functional levels that are assumed to change over time. These levels include ones that require involuntary treatment in restrictive settings, ones that require support for the necessary activities of daily living, and ones that require intensive support during critical periods of stress.

The study identified a range of residential and support services that current evidence suggests will maximize client safety and functioning. Using computer implemented simulation, these "service packages" were combined with estimates of service unit costs and outcomes to estimate annual system direct service needs and costs for a fully operational system. This plan is referred to on the next page as "the Client Movement Model."

The plan represents the professional judgment of HSRI about the services and resources needed in Maricopa County. HSRI conducted a similar but less comprehensive evaluation of the service system in Maricopa County ten years ago. The current findings regarding the quantity and intensity of needed services in Maricopa County are consistent with that earlier study. The plan is also consistent with similar plans formulated by other states and communities and with findings for programs that provide the services needed by individuals with comparable needs and disabilities in communities.

The planning process yielded the following annual costs for the planned service system (Client Movement Model) once fully operational, taking into account client

arrivals and movement based on projected service utilization and outcomes (including deaths and service non-use for other reasons). Medication costs, administration costs, and adjustment formulas to generate the Exit Stipulation Costs for *Arnold v Sarn*, shown in Column 3, were provided by the parties to the planning process.

Column 1: Type of Cost	Column 2: Costs for All Clients- 100% of Estimate	Column 3: Costs Adjusted According to Exit Stipulation[1]
Full Funding per HSRI Model	$467,207,838	N/A
Client Movement Model (Direct Service)	$370,015,798	$269,050,475
Medications	$33,635,375	$24,457,371
Administration at 8%	$32,292,094	$23,480,628
Total Cost[2]	$435,943,267	$316,988,474
Total Cost Per Person	$30,576	$22,233

[1] The 1996 Stipulation on Disengagement establishes the remaining obligations in *Arnold v. Sarn.*

[2] The actual amount of new money needed will be less than these totals, depending on use of existing funding and resources.

August 16, 1999

The Arizona Service Capacity Planning Project

Statement by the Arizona Department of Health Services

As part of the Supplemental Agreement to *Arnold v. Sarn* dated December 22, 1998, the Arizona Department of Health Services retained an expert national consultant, the Human Services Research Institute (HSRI), to assist in delineating a system that could bring Arizona into compliance with the mandates of the Court in this case.

The result of this effort is the document titled The Arizona Service Capacity Planning Project. This Project represents many months of work analyzing data, developing program models and costs, and refining a cost-efficient approach for developing a comprehensive mental health system for seriously mentally ill people in Maricopa County. The model provides the Department with a current, systematic analysis of the needs of the seriously mentally ill in Maricopa County and of the supports, services, and resources necessary to meet those needs. The Department concurs with the client movement model presented in this Project by HSRI and believes that its conclusions represent a reliable estimate of what is required in order to have an opportunity to meet the State's requirements. The next steps are to share this information with the Arizona Mental Health Services Task Force for their consideration and to discuss with the Court Monitor and the plaintiffs the highest priority areas defined in the Project and the desired budget to request in order to begin phasing in the program as rapidly as feasible.

Presentation by Carol Ann Lockhart, Ph.D.
Before the Arizona Mental Health Task Force
Arizona Senate Hearing Room
September 26, 1999

Thank you Mr. Chairman for the opportunity to present a summary of the first of a series of policy papers to be sponsored by the St. Luke's Charitable Trust, Mental Health Dissemination Network.

My expertise is in overall health care systems and health policy, not specifically the details of clinical care for the mentally ill. As such, this paper was done to assess the value and cost of the new drugs currently being used to treat the seriously mentally ill.

This was deemed important to do because of the real cost increases experienced by programs using all of the new psychotropic medications now available in the market.

Even though there is widespread use, there remains confusion about whether the value is worth the cost. This paper addresses that question.

I realize all of the committee members have particular knowledge of and experience with mental health issues. I also understand each has a copy of the paper, so I will take this time to summarize the paper and then respond to questions from the members.

This paper looked at the use of new psychotropic medications with the seriously mentally ill- people with serious mental illnesses that are persistent & disruptive of daily life, unless they are offered the care necessary to control their symptoms.

For most, the illnesses experienced can be controlled, just as diabetes and heart disease can be controlled, with ongoing medications, treatments and supportive life styles.

You are considering today, a proposed scope of services and budget requirements developed for the Arizona Service Capacity Planning Project. It suggests various levels and types of services and care.

The work for this paper suggests the need for some services may actually increase as effective treatment with medications allows people to take on tasks and work, and to

C. Lockhart Associates
1982 Tempe, Arizona 85283-2366
(480) 345-9445; Fax 839-4626

Overall, the findings from the paper show the new psychotropics are the current clinical standard of care and that the cost of medications themselves are worth the value they offer to the patients, their families and society. For the seriously mentally ill to fully function within society, however, they will require a wide range of services, not just medications.

The studies that have been done suggest there are real savings, particularly in the use of hospital care. But, there are also some added costs beyond that of the medications.

1. The number of hospital admissions and length of stay for those admissions significantly drop for SMI patients treated with antipsychotic and antidepressant medications. Numerous studies document this.

   What is less clearly documented is the change in the use of other services. This is due, in part, to the newness of the use of these drugs with these populations and the lack of completed research. A number of studies are underway.

2. One good example of the type of research needed was done by our sister state, Nevada. The Nevada Division of Mental Hygiene and Mental Retardation completed a study in January of this year. (Georgia also did a similar study with similar findings.)

3. It showed an overall decrease in hospital days for schizophrenia patients on the newer atypical antipsychotic drugs. There was an overall decrease of 4 days for patients and a 46.4 reduction in costs. (ADHS assumed a 3 day decrease in hospital stays in their 1999 budget proposal for increased funding of antipsychotics.)

4. For severely depressed patients there was a 37.5% drop in hospital admissions for patients using what are called the SSRI's (drugs such as Prozac, Paxil and Zoloft), a 31.9 percent drop in hospital days, and 9.1 percent shorter lengths of stay.

5. In both cases, however, care outside the hospital increased, particularly in the area of housing days
   since patients were no longer confined to the hospital.
   (12.7% for schizophrenic patients & 6.2 for depressed patients).

   There was a decrease in ambulatory crisis
   management (15.5% for Schizoprhenic & 36% for
   depressed patients).

6. Counseling services increased (59.7% schizophrenic & 8.1% depressed patients)

7. Overall costs for care outside the hospital, and not including medications, increased 13.3% ($5.44/day) for Schizophrenic patients & 10.3% ($2/day) for depressed patients.

Other studies that looked at depressed patients in general, not the SMI population, found that:

1. they consume 2-4 times more medical services than those without mental illness;
2. report significant numbers of days of functional disability that decreases with treatment (over 12 months disability days fell from 79 days to 51 days); and
3. cost $24 billion dollars annually in days of work lost to absenteeism.

The cost of newer medications are higher than that of the older drugs. SMI patients in Arizona can receive the older antipsychotic drugs for an average of $25/person/month. The newer drugs cost an average of $270/person/month.

Antidepressants such as Prozac, Paxil, Zoloft and others called SSRI's are available in the drug formulary at an average of $60-100/person/month. The older antidepressants cost an average of $25/person/month.

In the area of mental health, patients and providers of care are asked to show how the new medications offered save money in other areas of the behavioral health system or in the costs of other types of medical care a patient might receive.

This is referred to as medical and behavioral cost offsets. In other words the cost of the mental health medication or treatment is expected save money elsewhere in the behavioral or medical care system.

All new medical technologies are asked to justify their costs. Usually it is enough that the technology does what it is supposed to do - cure or treat. If it cures or prevents, it is called a "full" technology. If it treats and manages symptoms but does not cure, it is called a "half" technology.

In reviewing the literature for this paper, it became clear that mental health technologies of all kinds were treated as though they were full technologies. Full technologies are asked to justify their use by demonstrating that they avert the costs of other types of care. An immunization is a good example of a full technology- it prevents a disease from occurring and thereby avoids any costs except that for the production and administration of the immunization.

The new psychotropic drugs cannot avert all other costs in the behavioral or medical care system. It does shift them to different categories of care and in some cases reduces them significantly, as in hospitalization.

Because of this confusion, a framework for assessing the value of medications is suggested. It can be applied any time new drugs come forward, and continuing developments in technology suggest state legislatures and private insurers will be repeatedly asked to assess and pay for new medications for mental health care.

Eight categories of questions are suggested.

1. Is the drug FDA approved?
2. Is the technology (medication) a genuine innovation in treatment?
3. Is the health status of the patient at stake?
4. Is the medication the clinical standard of care?
5. Is increased cost due to improvements in ability to treat?

6. Is there a direct impact on mental health costs?
   Is there an indirect impact on medical costs (medical cost offsets)?
7. Is there an impact on the family?
8. Is there an impact on society?

The first five are the key questions. If they are answered in the affirmative, it suggests the new medication(s) should be eligible for coverage even at greater cost. They focus on improved health outcomes and health status for the patient and determine whether the technology is to be covered, not the behavioral or medical cost offsets, or family, or social impact as discussed in the last 3 questions.

My concluding observations are these:

1. New psychotropics offer true innovations in treatment and hold promise for an improved quality of life, health outcomes and health status for the seriously mentally ill.
2. Not all SMI patients who might benefit from newer medications are able to receive them. Even with the $10 million appropriation in 1999, only about 70% of those who might benefit from antipsychotics will be able to receive them. Budget constraints in categorically defined programs limit the types and quantities of services patients can receive in different areas of the state.
3. Medical care is not provided to those SMI patients who do not qualify for AHCCCS, or about two thirds of those who are deemed SMI. Such fragile individuals require coordinated mental health and medical care services to achieve their best level of functioning.
4. Arizona could lead the nation in creating an integrated medical and mental health model of care for its vulnerable citizens (as it did in the creation of AHCCCS).
5. Mental health technology (including medications) should be judged according to a criteria similar to that required of medical technologies.
6. Arizona government is a major purchaser of care. It must define expected outcomes and hold contractors accountable for meeting them, such as the number of patients on newer psychotropic medications.

7. A total of 75% of the antidepressants used are used outside the mental health community. Evidence suggests diagnoses and use of psychotropic medications are poorly understood by the general medical practitioners. State and private groups should explore how to improve the treatment of the mental health of the general population.
8. The use of psychotropic medications with the general public is increasing their level of understanding about mental illness. They will, over time, begin to demand that their body and mind be treated in the same systems and without restrictions. We are not there yet, but such a system is needed for the SMI and all consumers of mental health and medical care services.

CONSUMER COPAYMENT SCHEDULE: SERVICES

MONTHLY ADJ. INCOME			FAMILY SIZE					
			1	2	3	4	5	6
0	-	938	0	0	0	0	0	0
939	-	1007	5	0	0	0	0	0
1008	-	1076	10	0	0	0	0	0
1077	-	1145	15	5	0	0	0	0
1146	-	1214	20	10	0	0	0	0
1215	-	1283	25	15	0	0	0	0
1284	-	1352	30	20	5	0	0	0
1353	-	1421	35	25	10	0	0	0
1422	-	1490	40	30	15	0	0	0
1491	-	1559	45	35	20	5	0	0
1560	-	1628	50	40	25	5	0	0
1629	-	1697	55	45	30	10	0	0
1698	-	1766	60	50	35	10	0	0
1767	-	1835	70	55	40	15	5	0
1836	-	1904	80	60	45	15	5	0
1905	-	1973	90	65	50	20	10	0
1974	-	2042	100	70	55	20	10	5
2043	-	2150	100	75	60	25	15	5
2151	-	2257	100	80	65	30	15	10
2258	-	2364	100	85	70	35	20	10
2365	-	2471	100	90	75	40	20	15
2472	-	2578	100	95	80	45	25	15
2579	-	2685	100	100	85	50	25	20
2686	-	2792	100	100	90	55	30	20
2793	-	2899	100	100	90	60	35	25
2900	-	3006	100	100	95	65	40	25
3007	-	3113	100	100	100	70	45	30
3114	-	3220	100	100	100	75	50	30
3221	-	3327	100	100	100	80	55	35
3328	-	3434	100	100	100	85	60	35
3435	-	3541	100	100	100	90	65	40
3542	-	3648	100	100	100	100	70	45
3649	-	3775	100	100	100	100	75	50
3776	-	3862	100	100	100	100	80	55
3863	-	3969	100	100	100	100	85	60
3970	-	4076	100	100	100	100	90	65
4077	-	4183	100	100	100	100	95	70
4184	-	4290	100	100	100	100	100	75
4291	-	4397	100	100	100	100	100	80
4398	-	4504	100	100	100	100	100	85
4505	-	4611	100	100	100	100	100	90
4612	-	4718	100	100	100	100	100	95
4719	-	UP	100	100	100	100	100	100

Arizona Department of Health Services
Behavioral Health Services
Policy and Procedures Manual

Effective Date: 4/15/95
Last Revision Date: 2/27/95

CHAPTER 2 ADMINISTRATIVE AND PROGRAM SUPPORT SERVICES
POLICY 2.5 CO-PAYMENT POLICY

A. PURPOSE: To ensure that appropriate co-payments are assessed and collected from clients.

B. SCOPE: RBHAs and their service providers.

C. POLICY: When meeting the financial criteria, clients will be assessed a co-payment for services to assist in paying the cost for their care. Such assessments shall be based on information collected from the client, and shall take into account the client's ability to pay. No client shall be denied services due to an inability to pay for their care. All third party payers shall be billed in accordance with the ADHS/BHS policy on Third Party Liability. In addition to any collection of co-payments, RBHAs and providers shall bill all other possible payers and treat state behavioral health funds as the payer of last resort. Through its policies the RBHA may delegate responsibilities of this policy to its providers. The RBHA retains all responsibility for monitoring its provider network to ensure compliance with this policy.

D. REFERENCES:

E. PROCEDURES:

1. Schedule of Fees

a. Providers develop a Schedule of Fees for the services they provide based upon contracted rates with the RBHA. The Schedule of Fees shall be reviewed and approved by the RBHA to ensure compliance with ADHS/BHS policy. Documentation of such a review shall be located in the RBHA's provider file.

b. Distribution of Fee Schedule

(1) RBHAs and their providers shall distribute a copy of the schedule of fees to the client at intake.

(2) RBHAs and their providers give notice of changes to the fee schedule or payment criteria by:

(a) Posting the information in a prominent place for review by clients, parents, designated representatives or persons legally responsible for the cost of care at least 30 days before the change becomes effective, unless the Federal or State government has issued a retroactive rate change.

(b) The RBHA may also mail a letter to all currently enrolled clients and ADHS at least 30 days prior to the effective date of the change.

12. Co-Payment Policies

a. RBHAs and providers shall utilize the following co-payment policies:

(1) RBHAs and providers utilize a standard format to document the financial information required to assess co-pay and determine financial eligibility for service (Attachment A).

(2) With the exception of residential programs for adults with behavioral health problems, RBHAs and their providers utilize the Client Co-Payment Schedule: Services to determine the amount of the client's co-payment for services (Attachment B). For residential programs, the amount of rent a client must pay shall be determined in accordance with the ADHS/BHS policy Tenant Rent, Rent Reasonableness and Affordability. Services may be billed for in addition to the housing costs. In all cases, clients in residential programs shall have at least $60.00 of income remaining for personal use after co-payments for services and rent are deducted from their income.

(3) RBHAs and their providers incorporate the information on the Client Co-Payment Agreement in a client fee agreement.

(4) RBHAs and their providers are responsible for coordination of benefits. When ADHS/BHS is the secondary payer, the provider will receive payment from ADHS/BHS for an amount no greater than the contracted rate.

b. Co-payment policies include the following provisions:

(1) RBHAs and their providers do not assess co-payments for services that are reimbursable by Title XIX if the client is Title XIX eligible and enrolled with a RBHA.

(2) Co-payments may be assessed for non-Title XIX reimbursable services provided for Title XIX enrolled individuals.

(3) This policy does not cover prescriptions or methadone maintenance services. Co-payments may not be assessed for prescriptions or methadone maintenance services, unless prior approval is received from ADHS in writing.

(4) Parents or guardians of a child with an Individualized Educational Plan that requires residential care for the child are requested to make a voluntary contribution of the co-payment amount in accordance with the Co-Payment Schedule. However, they are not required to pay co-payments for IEP related services. They may be required to make co-payments for other services.

(5) When a person is in need of emergency services, RBHAs and their providers first provide emergency treatment and afterward assess the client's co-payment liability.

(6) Clients who decline to disclose third party coverage or financial information are assessed total service costs. When a client has a serious mental illness, total service costs shall not be assessed if the failure to disclose such information is due solely to the client's mental illness.

3. Client Co-Payment Agreement

a. The co-payment agreement provides for reduced charges based on ability to pay.

b. The co-payment agreement establishes:

(1) The client's share of expenses, expressed as a percentage of the full fee, for various family sizes and adjusted income levels; and

(2) No client shall be charged more than the cost of the service(s) rendered.

c. Family Size and Income

(1) Family size and adjusted monthly income are used to determine the client's ability to pay for services.

(2) Family means the client plus any immediate family member who has a relationship of financial responsibility with the client.

(3) Total Monthly Income

(a) Monthly income means the income received during the 30 days prior to the date of the client's eligibility screening or an average of the preceding six months, whichever is less.

(b) Total monthly income means income received from all sources.

(c) Total monthly income includes all after-tax earnings from employment, self-employment, military pay, or any other sources; unearned income from sources such as child support, alimony, unemployment insurance, social security, disability benefits, supplemental security income, gifts, interest and dividends; and any other private or governmental source.

(d) Total monthly income does not include income that is anticipated but not yet received, including benefits for which an application is pending.

(4) Adjusted Monthly Income

(a) Adjusted monthly income is calculated by subtracting certain costs as follows: existing medical and medical insurance payments, sheltered income in an approved Plan To Achieve Self-Support (PASS) plan, child support payments, spousal maintenance, and any other court ordered dependent care and support actually paid.

d. Client Co-Payment Schedule Exception Requests

(1) Standard Co-Payment Terms and Exceptions

(a) Clients are expected to pay the full amount of the co-payment at the time services are rendered.

(b) RBHAs and their providers offer two types of co-payment exceptions to clients who state they are unable to meet the standard co-payment terms: (1) installment payments, and (2) co-payment waivers. As delineated in their policies and procedures or contract, RBHAs may require providers to obtain approval from the RBHA prior to granting co-payment exceptions to the client.

(c) Installment payments are preferred to co-payment waivers.

(2) Installment Payments

(a) Clients who state they are not able to pay the full amount of co-payment charges at the time the charges are incurred may request to pay the balance in monthly installments. Clients may pay the entire co-payment balance at any time.

(b) RBHAs and their providers establish criteria for approving installment payment requests.

(c) Clients provide documentation to support their installment payment requests.

(d) RBHAs or their providers determine a minimum monthly payment amount.

(e) RBHAs and their providers may not charge interest, penalties, or transaction fees for co-payments.

(3) RBHAs and their providers may approve client requests to waive all or part of the assessed co-payment or installment due to exceptional circumstances which affect the clients ability to pay for services.

(a) Clients provide documentation to support their waiver requests.

(b) Exceptional circumstances may include, but are not limited to: living expenses, other health care expenses not included as part of the co-payment determination, repayment of debt previously acquired, an unforeseen financial crisis, or therapeutic contra-indication.

4. Computation and Documentation of Co-Payments

a. At intake, RBHAs and their providers inform clients, parents, designated representatives or persons legally responsible for the cost of care of the co-payment policies and provide clients with a copy of the schedule of fees, developed by the RBHA, the client co-payment schedule for Treatment Services, methadone services (if applicable), prescriptions (if applicable), and the co-payment agreement that will be used to calculate the client's co-payment amount.

b. Client Financial And Third Party Information

(1) At intake and at least annually thereafter, or whenever client financial circumstances change significantly, RBHAs and their providers obtain income and third party payer information from clients.

(2) RBHAs and their providers identify any third party coverage based on information provided by AOC, ADES, ADYTR, ADHS, AHCCCS, AHCCCS health plans and/or ALTCS Program Contractors.

(3) Funding provided by AOC, ADES, ADYTR, AHCCCS, ALTCS, or AHCCCS Health Plans is not considered third party coverage or a co-payment amount.

(4) RBHAs and their providers must verify income information by requiring documentation or making outside inquiries. Confidentiality and information release requirements are followed when outside inquiries are made.

c. RBHAs and/or their providers calculate the amount of the client's co-payments, enter the co-payment terms and co-payment limit on the co-payment agreement, and submit the co-payment agreement to the client for review and signature.

d. When applicants or clients request a co-payment exception, RBHAs and/or their providers review each request, document the determination in the client's record, and provide a copy of the determination to the client.

e. RBHAs and/or their providers inform applicants and clients of the organization's and ADHS' grievance/appeals policy and procedures related to appeals of co-payments.

f. RBHAs and/or their providers document the client's co-payment determination.

(1) Providers assigned to act on behalf of a RBHA may submit a copy of the co-payment agreement to the RBHA, along with intake, treatment plan, and service authorization request materials, as required.

(2) RBHAs and their providers file a copy of the co-payment agreement in the client's record.

(3) Providers and RBHAs are required to report all revenue earned through client co-payments in their annual independent financial audits.

5. Client Billing

a. The RBHA or provider calculates the client co-payment and bills the client in accordance with their established internal billing procedures.

b. The RBHA monitors fee assessments during periodic provider reviews. RBHAs develop monitoring procedures to ensure that co-payments for treatment services are set within the guidelines of this policy, and no overcharging results. If it is determined that overcharging has occurred, that amount will be refunded to the client within seven calendar days of the date in which the overcharge was detected.

c. RBHAs and their providers may utilize collection agencies as appropriate and necessary to collect co-payments.

d. Termination of Services for Non-Payment of Co-Payment

(1) RBHAs and their providers may consider terminating services for non-payment of the co-payment only after all other options, including informal discussion with the client, do not result in resolution. All discussions must be documented in the medical record.

(2) RBHAs and their providers may not deny services when clients refuse to pay for services if non-payment is due solely to the client's mental illness or if termination of services would result in serious harm to the client or others. Rather, the issue of payment is dealt with in the treatment process.

(3) When a client has a serious mental illness, services will not be terminated because of non-payment of co-payment. The issue of payment is dealt with in the treatment process.

(4) Prior to terminating services to any client for non-payment of co-payment, RBHAs and their providers provide the client with a notice of intent to discharge and advise the client of the right to appeal the termination decision.

F. APPROVED BY:

Charles P. Carbone
Associate Director
Arizona Department of Health Services

Arizona Department of Health Services

ARIZONA STATE HOSPITAL
A Presentation made to the Mental Health Task Force
November 9, 1999

Set "A"

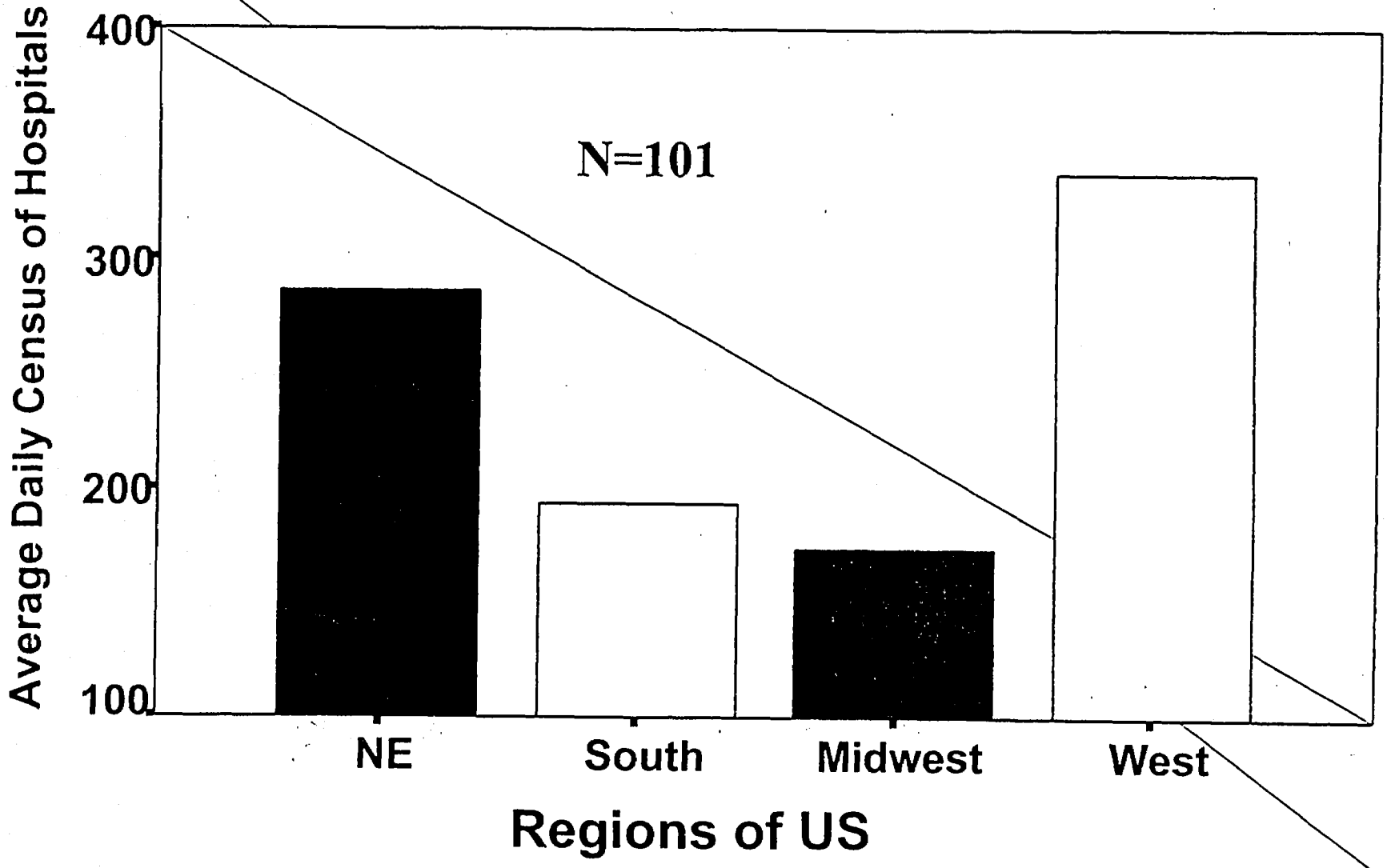
Arizona State Hospital

Update

- Medicare & JCAHO
- Planning
- Sunset Review
- Alhambra & Aspen Facilities

ASH US Psychiatric Hospital Survey - 1999

Average Daily Census of Hospitals by Region



"Qualified" Hospitalization

- **Arizona Statute & Rules**
  - Mentally Ill
  - Danger to self or others
  - Persistently and acutely disabled, or gravely disabled
  - Appropriate treatment in the least restrictive environment
- **Medicare**
  - Psychiatric diagnosis
  - Active treatment
- **JCAHO**
  - Appropriate care
- **RBHA Agreement**
  - Alternate inpatient care has not been successful
  - No less restrictive alternative available
  - Axis 1 mental disorder

Census Projections:

Average Adult* Patients per day

	Civil	Forensic	Total
1999	166	130	296
2000	167	138	305
2001	167	149	316
2002	168	160	328
2003	169	172	341
2004	170	200	370

*There was an average of an additional 12 adolescent beds used per day during 1999

1999 ASH Average Daily Census

- Civil = 160
- Forensic = 121
- Adolescent = 14

- TOTAL = 295

SELECTED FACTORS IMPACTING CENSUS PROJECTIONS

- 1. Increase in the number of community residential beds
- 2. Increase in hospital diversion efforts (assertive outreach teams etc.)
- 3. Increased availability of new generation psychiatric medication
- 4. Increase in jail diversion efforts
- 5. Increase in the number of community based psychiatric stabilization facilities
- 6. Population growth
- 7. Incidence of SMI occurrence
- 8. Related factors

Civil Hospital Construction Recommendations

	Phase 1 (2000 – 2003)	Original 8/99	Phase 2* (2003 – 2006)	Original 8/99
Civil	200	176	100	88
Forensic	200	188	100	92

* If Necessary

Civil Hospital Construction Timeframe

◆ Step 1 - Select Architect	3 months
◆ Step 2 - Plans & Blueprints	12 months
◆ Step 3 - Design Approval	2 months
◆ Step 4 - Bidding Process	1 month
◆ Step 5 - Award Contract	1 month
◆ Step 6 - Demolition	3 months
◆ Step 7 - Construction	15 months
Total time estimate	**37 months**

Under Development

Comparative ASH census projections using the HSRI ("Gap Analysis") methodology

Beds @ 100%, 50% & 0%

Adolescent Unit Questions

- Size?
- Location?
- State or privately operated?

ARIZONA DEPARTMENT OF HEALTH SERVICES
ARIZONA STATE HOSPITAL
2500 East Van Buren St.
Phoenix, AZ 85008

Appendix B to Mental Health Task Force Report, November 30, 1999

SUMMARY OF CAPITAL DEVELOPMENT PROPOSAL

PROJECT	COST	COST PER BED	TIME FRAME
Civil Hospital (176 beds)	$30,599,745	$173,862	FY 2001 - 2003
Adolescent Facility(16 beds)[1]	3,907,088	244,193	FY 2002 - 2004
Forensic Facility (188 beds)[2]	11,803,731	62,786	FY 2003 - 2006[3]
SVP Facility - (136 beds)	12,169,149[4]	89,479	FY 99 - 2003
Sitework & other project related expenses[5]	17,320,287		
Total	**$75,800,000**		

an-capital.089

---

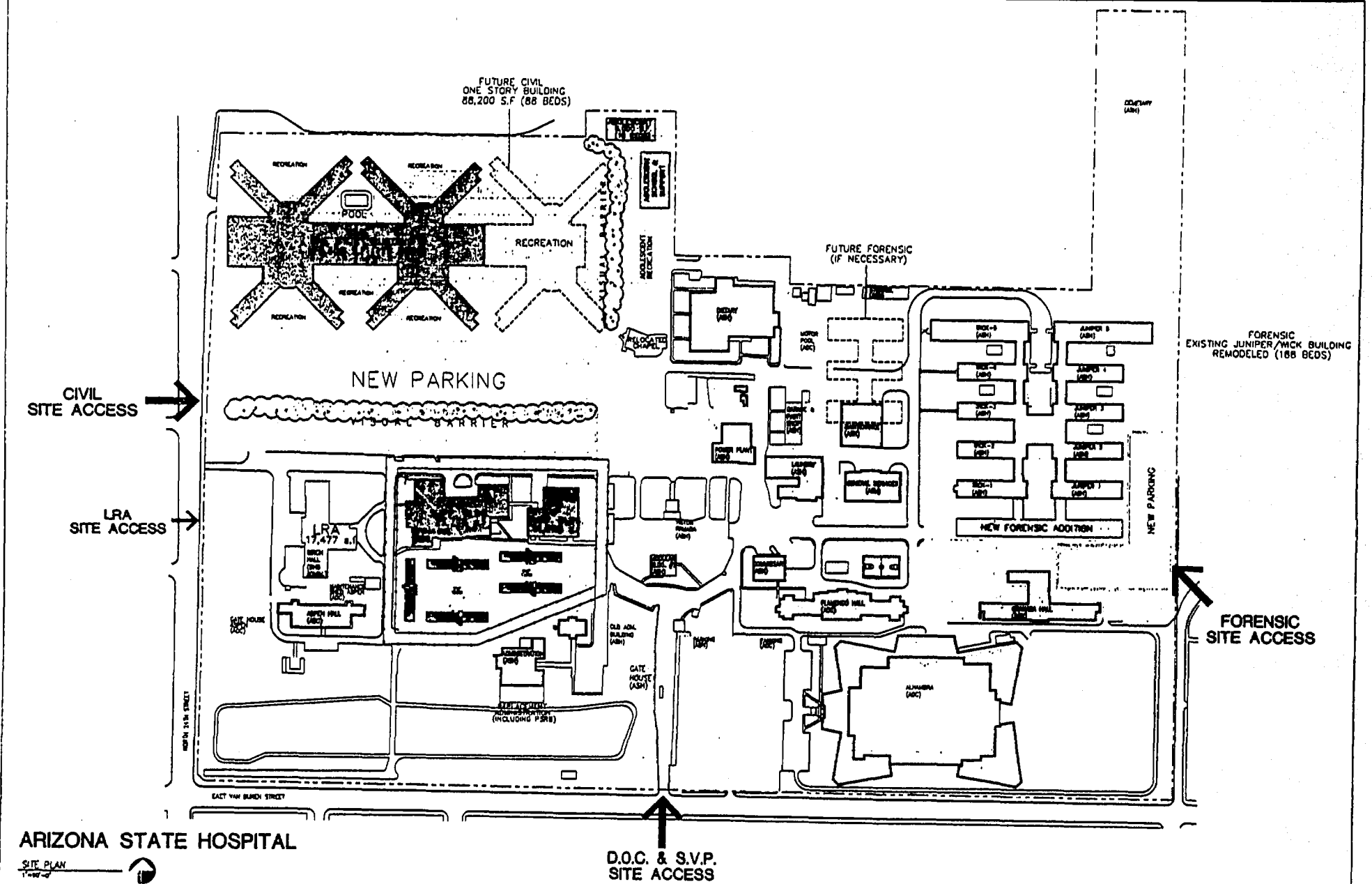
[1]It is recommended that the Adolescent program be placed in location other than Arizona State Hospital

[2] Does not include 20 bed Conditional Release Unit

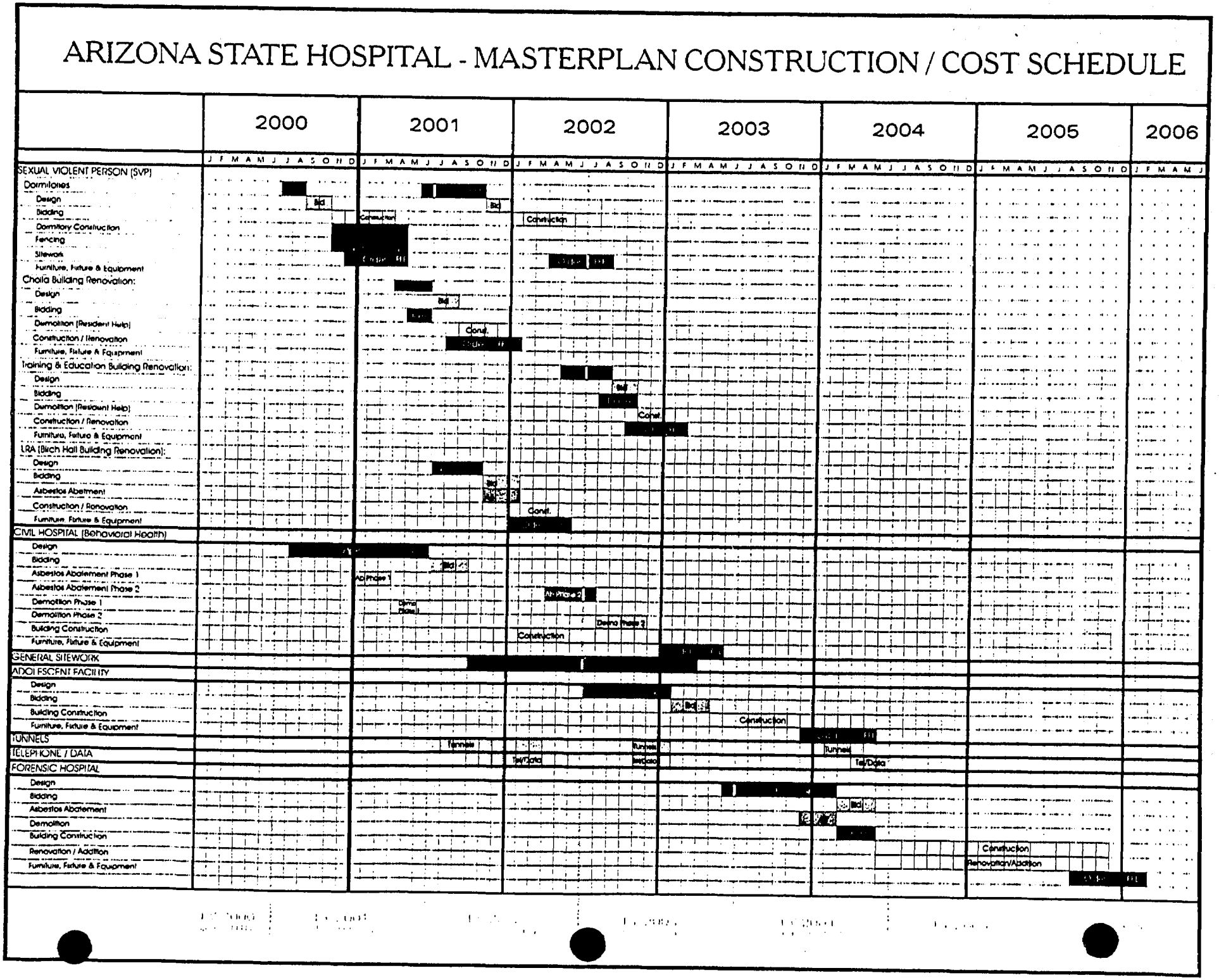
[3] Forensic renovation begins after civil patients move to new facility

[4]$4,000,000 of this amount was appropriated in the FY 2000 capital budget

[5]Demolition of old buildings, asbestos abatement, tunnels, voice/data cabling, furniture & fixtures, and contingency (7%)


FUTURE CIVIL
ONE STORY BUILDING
88,200 S.F (88 BEDS)
RECREATION
POOL
FUTURE FORENSIC
(IF NECESSARY)
FORENSIC
EXISTING JUNIPER/WICK BUILDING
REMODELED (168 BEDS)
NEW PARKING
CIVIL
SITE ACCESS
LRA
SITE ACCESS
LRA
17,477 s.f.
NEW FORENSIC ADDITION
NEW PARKING
FORENSIC
SITE ACCESS
D.O.C. & S.V.P.
SITE ACCESS
ARIZONA STATE HOSPITAL
SITE PLAN
PROPOSED SCHEME C
01/12/99

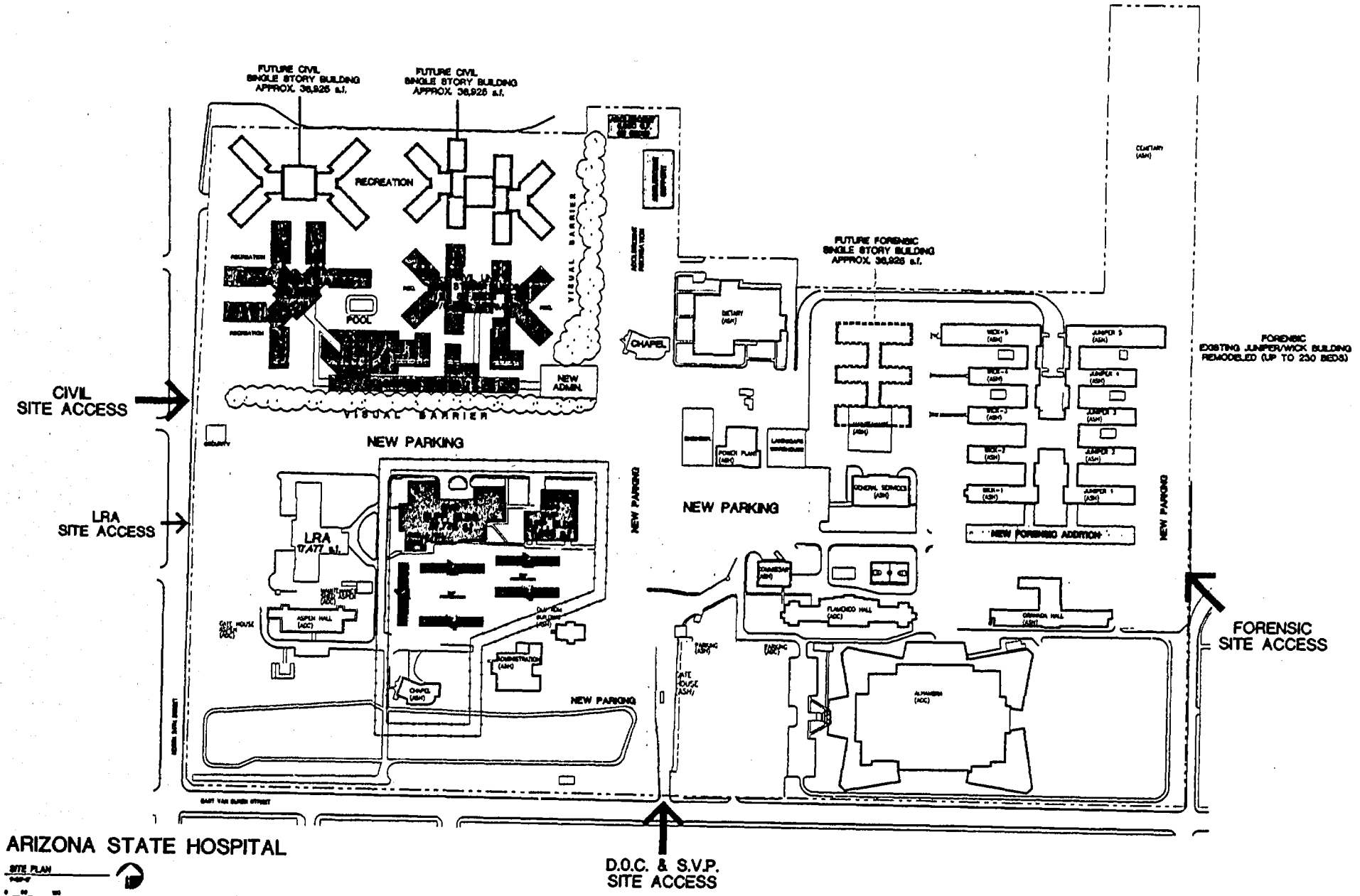
ARIZONA STATE HOSPITAL - MASTERPLAN CONSTRUCTION / COST SCHEDULE



ARIZONA STATE HOSPITAL - MASTERPLAN ESTIMATE OF PROBABLE COST

PRELIMINARY - FEBRUARY 2, 1999

	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY2006	SUBTOTALS
Sexually Violent Persons (SVP)								
Dormitories (2) Phase 1		$3,248,009						
Furniture, Fixtures, & Equip. (5%)		$162,400						
Fencing		$405,000						
SVP Sitework		$936,000						
Design (A/E) & Admin. (ADOA)	$437,120	$247,064						
Dormitories (2) Phase 2			$3,252,132					
Furniture, Fixtures, & Equip. (5%)				$173,989				
SVP Sitework			$202,650					
Design (A/E) & Admin. (ADOA)		$428,418	$144,796					
Cholla Renovation		$340,000						
Design (A/E) & Admin. (ADOA)	$70,896	$16,800						
Demolition	$0							
Furniture Fixtures, & Equip. (5%)			$42,000					
LRA (Birch Hall)			$1,080,000					
Design (A/E) & Admin. (ADOA)		$82,500	$21,600					
Demolition			$0					
Furniture, Fixtures, & Equip. (5%)			$54,000					
Training & Education Building				$264,600				
Design (A/E) & Admin. (ADOA)			$40,653	$5,292				
Demolition								
Furniture, Fixtures, & Equip. (5%)				$13,230				$12,189,149
Civil Hospital (Behavioral Health) (176 Beds)								
Asbestos Abatement - Ph 1		$614,714						
Asbestos Abatement - Ph 2			$117,486					
Demolition - Phase 1		$550,843						
Demolition - Phase 2				$160,172				
Building Construction			$17,529,561	$7,338,585				
Furniture, Fixtures, & Equip. (5%)				$1,243,407				
Design (A/E) & Admin. (ADOA)		$1,819,772	$746,733	$478,473				$30,599,746
General Sitework								
Construction		$1,654,818	$1,712,736	$885,327				
Demolition			$895,441					
Design (A/E) & Admin. (ADOA)		$297,598	$215,727	$174,541				$5,836,189
Adolescent Facility								
Building Construction				$2,396,800	$1,060,800			
Furniture, Fixtures, & Equip.					$172,880			
Design (A/E) & Admin. (ADOA)			$138,304	$103,728	$34,576			$3,907,088
Tunnels		$872,522	$1,804,056	$1,863,067	$961,039			$5,500,685
Telephone / Data			$400,000	$414,000	$214,000			$1,028,000
Forensic Hospital (140 Beds)								
Asbestos Abatement				$375,146				
Demolition				$234,000				
Renovation					$4,668,300	$2,000,700		
Addition					$2,212,000	$948,000		
Furniture, Fixtures, & Equip. (5%)							$491,450	
Design (A/E) & Admin. (DOA)			$418,361	$437,626	$18,149			$11,803,731
TOTALS	$508,016	$12,176,458	$28,816,237	$16,561,983	$9,341,744	$2,948,700	$491,450	$70,844,587
CONTINGENCY	$0	$851,715	$2,015,628	$1,158,472	$653,433	$206,255	$34,376	$4,955,413
GRAND TOTAL	$508,016	$13,028,173	$30,831,865	$17,720,455	$9,995,177	$3,154,955	$525,826	$75,800,000



ARIZONA STATE HOSPITAL

SITE PLAN

PROPOSED SCHEME C.2

01/12/99

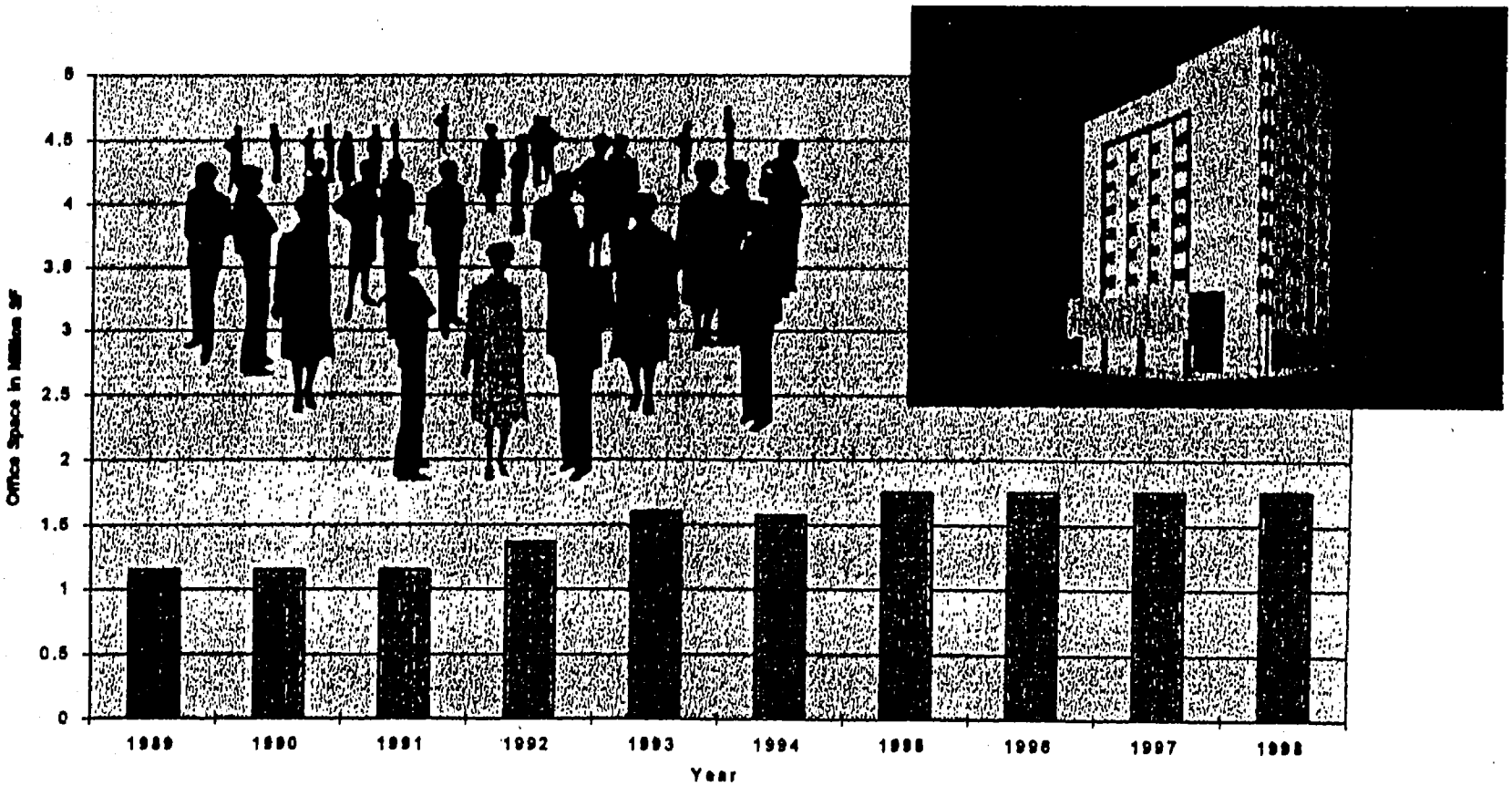
Arizona State Government Capitol Mall Master Plan

The Arizona Department of Administration
J. Elliott Hibbs, Director

The Mission

Provide the right service , in the right place, at the right time.

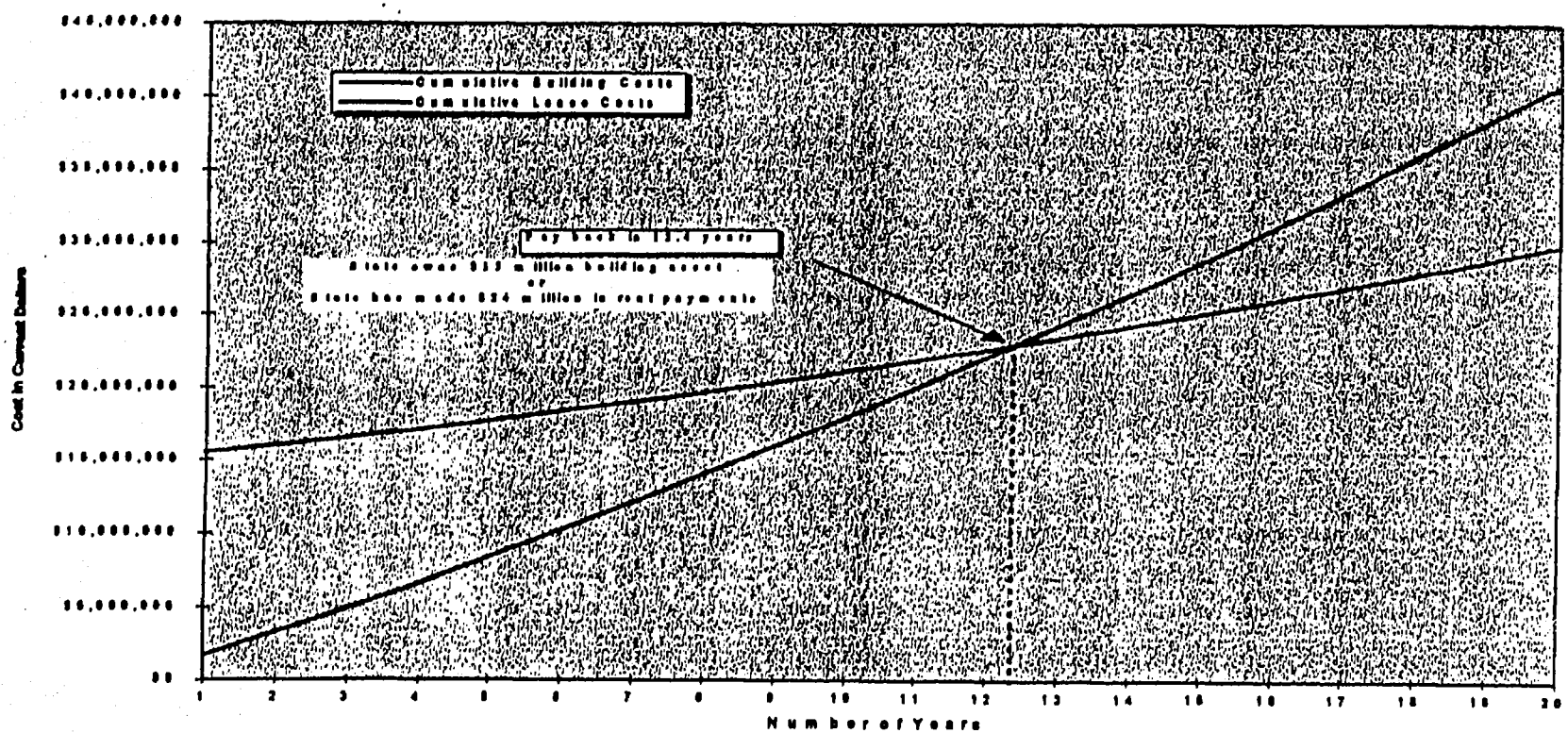
Office Space Available In The Capitol Mall Area Has Not Increased To Meet The Service Needs Of An Increasing Population



Own and operate if there will be a space requirement for more than 10 to 15 years...

Lease if the space requirement will be less than 10 to 15 years...

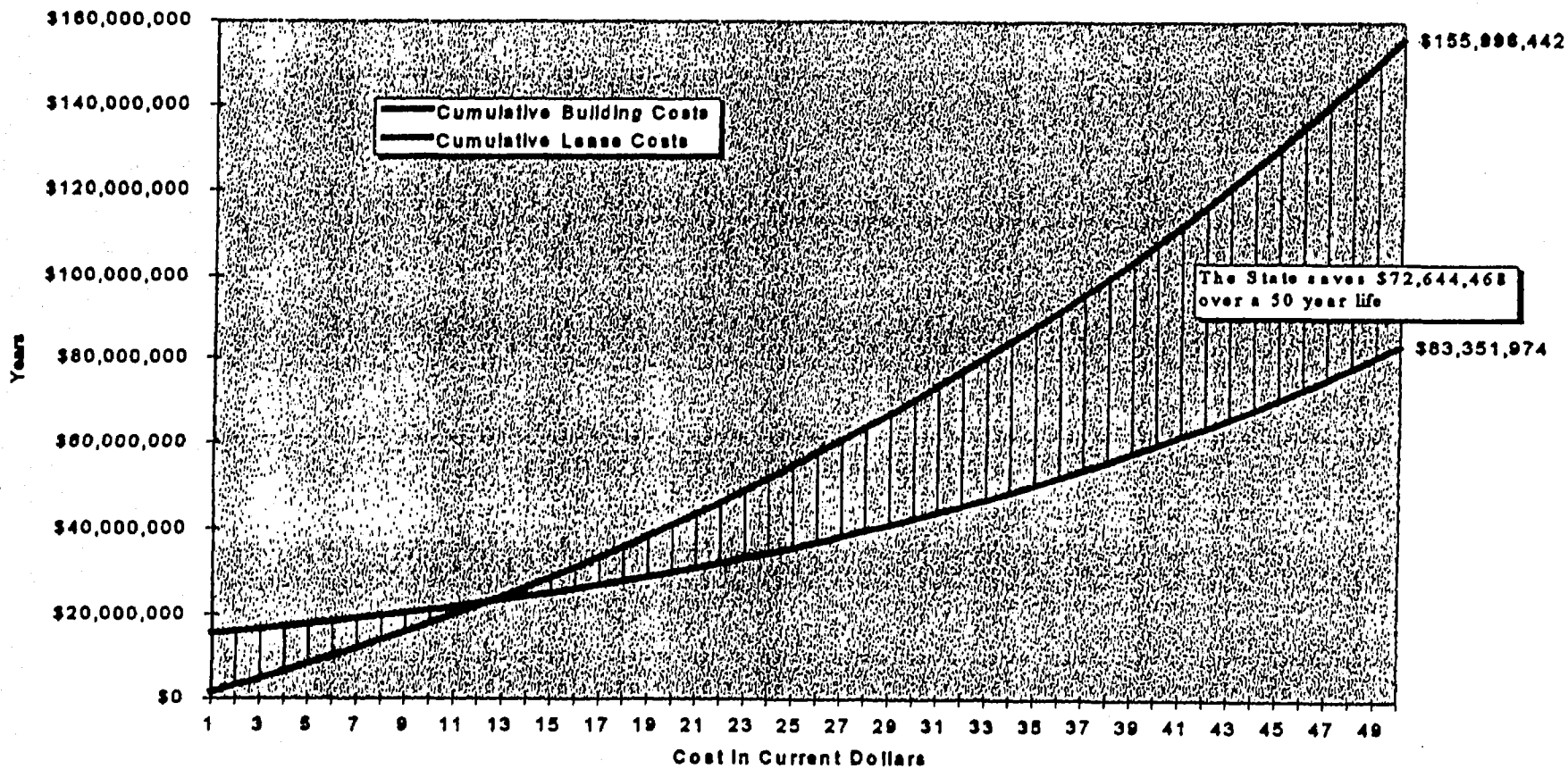
✓Cost Benefit



- The graph plots the costs for a hypothetical 100,000 S. F. of new office space. The above considers the cost of building and operating this space over the first 20 years versus the cost of leasing comparable space over the same period.
- The State of California builds office buildings if the payback is 25 years or less.

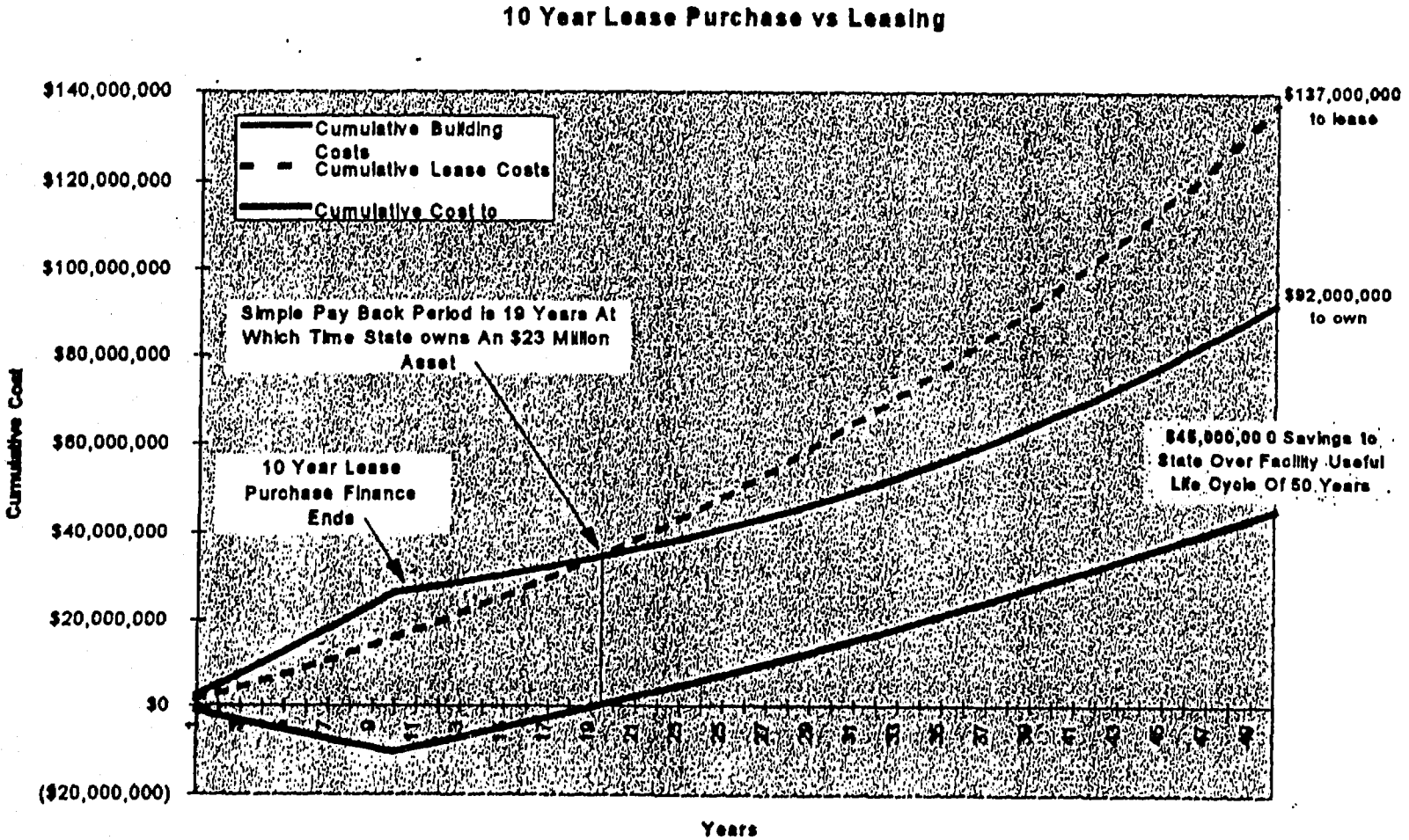
The State saves $72,000,000 over a 50 year life cycle by owning versus leasing a hypothetical 100,000 square feet of office space...

✓Cost Benefit

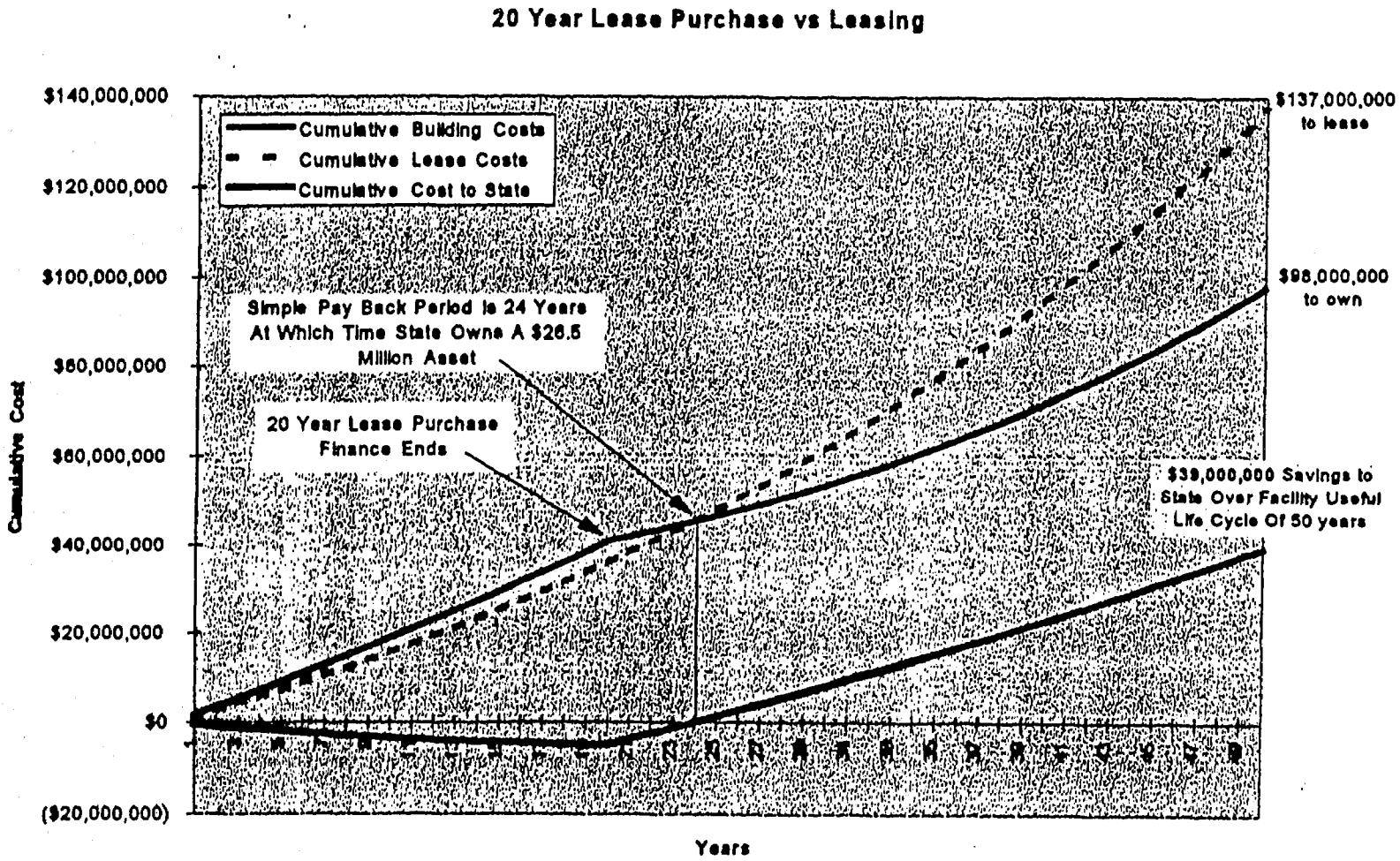


Based on construction costs of $150/SF, annual operating costs of $5/SF versus leasing costs of $16/SF. Inflation costs figured at 2.5%/year for both annual operating costs on owned building and leasing costs.

If the State cannot afford the total initial capital expenses, the State can still save $45 million over a 50 year life cycle by utilizing a ten year lease purchase finance method versus leasing a hypothetical 100,000 square feet of office space for the same time period.



If the State cannot afford the total initial capital expenses, the State can still save $39 million over a 50 year life cycle by utilizing a twenty year lease purchase finance method versus leasing a hypothetical 100,000 square feet of office space for the same time period.



Is there a scenario that works?

- The state can issue "request for proposals" on build to suit/lease to own.
- The state can evaluate the proposals and award to the best candidate
- To be successful the state must be able to match existing/projected lease rates with the new lease rate necessary to construct the buildings

- Is this feasible?
- Is there interest?

What we want and what we can offer

Needs

- Obtain State Office Buildings in the Capitol Mall, without the use of state issued C.O.P.
- Use Build-to-suit/lease to own as a method to avoid the need for additional funding appropriations (lease payments not to exceed present/projected rates

Opportunities

- The State can provide the land
- Lease structure intended to remain tax exempt
- Entertain commercial space within the buildings, i.e., food, banking or other services
- State can operate the buildings
- State has $10,500,000 in leases as a revenue stream

Constraints

- State must maintain a fiscal-out termination clause in any lease, this is statutorily required
- Lease costs for new buildings need to be less than existing/projected lease rates, can't be more than we pay now
- Existing political climate doesn't favor COP's and there is little legislative support for state construction of new buildings

PLTO
PRIVATIZED LEASE TO OWN

- PLTO Privatized Lease to Own, a sage and wise approach
- PLTO, Something very far out
- PLTO allows the State to leverage the bi-annual budget to achieve capital facilities by avoiding large up-front capital appropriations. PLTO allows the payment for a facility over a term with the State owning the facility at the end of the term. PLTO is not COP (Certificates of Participation)
- PLTO allows a developer to do what they do best and design-build a facility according to the State's needs. PLTO saves time and money. The architect and contractor are on the same team and are not fighting each other. The developer is responsible for the financing.
- PLTO is a lease contract at a specified cost over a specified term, with an annual out clause.

Appendix D to Mental Health Task Force Report, November 30, 1999

Arnold vs. Sarn

Overview of Today's Presentation

- Original Order and Blueprint
- Exit Stipulation
- Independent Review
- Supplemental Agreement
- Best Effort
- Statewide Applicability

Arnold vs. Sarn from Inception to Supreme Court Affirmance

- Arnold v. Sarn class action was commenced as a special action on March 26, 1981
- Defendants are the Arizona Department of Health Services, Arizona State Hospital, and Maricopa County
- Case assigned to the Honorable Bernard J. Dougherty of the Superior Court
- January 16, 1985 Judge Dougherty ordered the ADHS and County to provide a unified and cohesive system of community health care
- Final Judgement entered on August 1, 1986

- Defendents appealed the decision
- The Arizona Supreme Court removed the case from the Court of Appeals on its own motion
- In March 1989 the Supreme Court affirmed the trial court's findings

The Blueprint Era

- Linda Glenn appointed to serve as the Court Monitor in May 1991
- The Monitor's main responsibility was to negotiate and monitor the Implementation Plan also known as The Blueprint

The Implementation Plan was intended to ensure that, by September 30, 1995 the court's judgement as affirmed would be

- Fully Implemented
  - Comprehensive Mental Health System for class members established
  - Unnecessary and inappropriate hospitalization prevented

- In 1994 it was determined that the defendents would not achieve full satisfaction of the Blueprint requirements
- Negotiations entered into which resulted in the Joint Stipulation and Exit Criteria approved by the Court in February 1996

OVERVIEW OF EXIT STIPULATION REQUIREMENTS

Exclusive method for determining when the defendents have established a system sufficient to satisfy the requirements of state statutes as interpreted by the Arizona Courts.

- Classmember means a person who:

  1. is a resident of Maricopa County.
  2. is indigent,
  3. is seriously mentally ill, and
  4. would reasonably benefit from appropriate behavioral health treatment due to his or her mental illness.

Priority classmembers are individuals who are or who have been:

1. a resident of ASH.
2. a resident of supervisory care
3. a resident of a 24 hour residential program
4. a jail inmate with a major biological mental illness, or
5. hospitalized twice or more in a year, or a frequent recipient of crisis services

Arizona State Hospital

- Bed capacity at ASH will be no more than fifty-five (55) non-forensic beds for Maricopa County.
- At least eighty-five (85) of the classmembers will be individuals who had lengths of stay at ASH greater than one year.

Arizona State Hospital cont.

ADHS to make available and maintain community living arrangements and supports to ensure appropriate discharge of classmembers at ASH.

- Community Living arrangement means an array of flexible housing options with supports necessary to provide a classmember who moves from ASH or a supervisory care home with appropriate services in the most normal and least restrictive setting,

consistent with the individual's needs and preferences and without which the classmember would not be able to move appropriately from ASH or a supervisory care home and remain in the community.

"Appropriate supports" means case management, crisis intervention, respite services, meaningful day activity and/or supported employment services, and other support services for each classmember who moves from ASH or a supervisory care home to a community living arrangement.

- Substantial portion of costs for community placement to be reallocated from ASH

Since the joint stipulation was signed:

- 121 Maricopa County non-forensic classmembers have been placed into the community.
- As of June 30, 1999 Maricopa County SMI population is 99.

Supervisory Care and Board and Care Homes

- ADHS must provide 300 community living arrangements for classmembers living in Supervisory Care.
- At least 200 of the community living arrangements must be for classmembers who reside in supervisory care homes identified by the Court Monitor
- Must use "best efforts" to transfer all other classmembers who reside in supervisory care homes to alternative settings.
- Defendants are required to "not transfer. recommend for transfer. or assist others in transferring classmembers to any supervisory care home."
- Since the signing of the Exit Stipulation, ADHS has re-located over 203 people from supervisory care homes to new community living arrangements.

County Correctional Facilities

Utilize best efforts to develop one or more programs designed to review appropriateness and necessity for jail admission of class members and facililtate jail diversion

Provide all classmembers with a Special Needs Treatment Plan

Inpatient Services

Parties agree class members being admitted to ASH, in part as a result of the lack of a fully developed comprehensive crisis network.

Other class members may require acute or long term hospitalization and may be better served in alternative facilities associated with other medical providers.

- ADHS to provide additional $4.300,000 to the crisis system and keep crisis services as a priority when additional funds become available.

- ADHS shall take all reasonable steps to prevent unnecessary use of ASH for class members

- ADHS shall investigate the appropriateness and feasibility of alternatives and prepare a report for the monitor.

Service Development

- Reasonable efforts to ensure that adequate supported employment and other appropriate vocational services for classmembers are funded and provided through the Arizona Rehabilitation Services Administration (RSA) or any other agency established to utilize federal vocational funds.

- To the extent that, despite ADHS' efforts' RSA does not fully fund adequate supported employment and other vocational services on a long term basis, as needed by classmembers. ADHS will use its best efforts to obtain alternative funding for the continued provision of the same level of needed services.

- ADHS will make reasonable efforts to pursue and maintain federal funds for housing support services for classmembers.

- To the extent that, despite ADHS' effort, housing support grants currently funded by the United States Department of Housing and Urban Development (HUD) are not maintained or continued. ADHS will use its best efforts to obtain alternative funding for the continued provision of the same level of needed services.

- The annual budget requests of the director of ADHS to the Governor during the term of the Stipulation shall be sufficient to maintain the level of state funding which supports services for classmembers in Maricopa County as of July 1, 1994, as well as to fund the service development and and other requirements of this stipulation.

- The Director of ADHS shall use best efforts to ensure that the Governor fully adopts the agency's budget request for community services for individuals with serious mental illness in the executive budget to the Legislature. The Director will, as part of the Department's annual written budget request in accordance with Arizona law, provide the Legislature with the amount and rationale of ADHS budget request to the Governor, including why that level of funding is necessary to continue existing services and to develop the new community services required by this Stipulation, and will respond to legislative inquiries

Quality Management

- ADHS will establish and implement a quality management system that contains the processes delineated in the stipulation and is consistent with "accepted standards of practice in the professional judgement of the Deputy Director for the Division of Behavioral Health Services".

- The plan must be approved by the Court Monitor

Once the Monitor has approved the plan, any data and findings concerning compliance with numeric standards which is generated by an approved quality management system is "presumed to be valid, and plaintiffs shall bear the burden of proof to show that such data and numeric findings of that quality management system is erroneous".

The processes which address the adequacy of services offered by a program must measure the provider's compliance with the six regulatory categories governing:

- human rights
- client rights
- Individual Service Planning
- the client grievance procedure
- residential program standards
- nonresidential program standards

The process concerning the adequacy of services to individual classmembers must be sufficient to render a reliable judgement with respect to at least the following criteria:

- (a) whether the classmember has an ISP
- (b) whether the classmember is receiving services which are consistent with his/her ISP
- (c) whether the classmember is receiving services which are adequate, appropriate and least restrictive
- (d) whether the classmember is receiving services in the most normal and the least restrictive setting, according to the least restrictive means appropriate to the individual's needs.

Appendix A

Summary of provisions in the Implementation Plan that have been satisfied:

- Rules Promulgated
- Evaluation of persons in Supervisory Care and long term ASH residents
- Single Case Management Agency
- DHS shall not develop any programs prohibited by ¶126 after January 1, 1991
- After September 30, 1992 DHS shall not place a class member in any residential program of more than eight persons or in any residential program in an apartment setting where more than 25% of the apartment units are occupied by class members placed in such setting by or through DHS

- For purposes of service development and placement, DHS and its agencies shall have a preference for housing and residential programs of four persons or less.

Appendix B

Summary of Provisions of the Implementation Plan which have been incorporated in Agency Regulations:

- Rights
- Grievances
- ISP's
- ASH and County Annex class members have Individualized Treatment and Discharge Plan incorporated in ISP.

Appendix C

Selected Regulatory Standards and Degrees of Compliance for Exit Criteria

- Standards which refer to "priority clients" are to be applied without regard to the availability of resources.

- Parties agree that the total number of priority clients is assumed to be 3.000 and shall not exceed that number.

- For all other classmembers, ADHS must substantially meet their needs, as determined by their service plan. Standards which refer to non-priority classmembers "may consider" the availability of resources in determining compliance.

Specific items for Measurement include:

- Case Managers
- Clinical Teams
- ISP's within 90 days
- Periodic Reviews

- Substantial Changes to ISP require client consent
- The needs of priority clients are met, consistent with their ISP
- The needs of classmembers are substantially met.
- Classmembers participate in the ISP
- Special Assistance is provided

Disengagement Process

Upon completion of any individual provision of the Stipulation, a defendant may file a motion requesting the Court to find that it has complied with that particular provision and that a partial satisfaction of the Judgement with respect to that particular provision be entered.

During this Stipulation, defendants will meet with the Monitor and the plaintiffs every four months to discuss progress and obstacles.

Both of the defendants shall file an Annual Report

Either defendant may at any time prepare a final report to the Monitor regarding full compliance

If the Court determines that the defendant has complied with all the remaining provisions of this Stipulation, the Court shall issue an order, solely as to that defendant, declaring that the defendant is in compliance with this Stipulation and will enter into a full and final satisfaction of Judgment with respect to that defendant.

Throughout the term of the Stipulation, there shall be a Court Monitor

If unanticipated funding reductions occur notification is required, reasonable efforts to negotiate resolution is to occur, and any party may request that the Court modify the Stip.

If there is significant lack of progress or a pattern of noncompliance, the Court may modify the Stipulation

If the Stipulation is vacated the relevant provisions of the Implementation Plan, as determined by the Court at that time, shall be reinstated.

Any party may seek a modification of the Stip. The Court retains the inherent authority to interpret, clarify, modify, or enforce the Stipulation.

The parties agree that impossibility is a defense in any type of court action to enforce or compel compliance with the Stipulation, the Judgement, or the Implementation Plan.

Court Monitor's Independent Review

- Disruption in the system during 1997 and 1998 caused concern on the part of plaintiff's and the Court Monitor as to the status of priority members.

- In March of 1998 the ADHS agreed that the Court Monitor should conduct an Independent Review to examine the Defendant's efforts to satisfy the requirements of Paragraphs 10 and 41 (Appendix C) of the Exit Stipulation.

- The review was conducted in May and June of 1998

- Although strengths were identified the report concluded that the Defendant's have not been able to meet the performance standards articulated in the Exit Stipulation.

- As a result the parties negotiated the Supplemental Agreement which was approved by the Court in December of 1998.

SUPPLEMENTAL AGREEMENT

Provisions of the Supplemental are enforceable obligations that must be implemented to comply with all of the remaining provisions of the Exit Stipulation which apply to ADHS

If the Court finds that ADHS has complied with all of the provisions of the Exit Stipulation. then all of the obligations of the Supplemental Agreement shall be deemed satisfied, regardless of completion.

Purpose

The Supplement Agreement sets forth specific standards and obligations for implementing the purpose and principles of the Exit Stipulation.

It is not intended to create new obligations which exceed the purpose and scope of the Exit Stipulation .

Principles

ADHS must evaluate the unmet needs of classmembers and develop a specific level of additional services to address these unmet needs through new resources

ADHS must develop a significantly enhanced provider capacity. particularly with respect to vocational. housing. and substance abuse services

ADHS must develop and implement strategic plans for each of these programs areas.

RBHA will accept. support. and be obligated to implement the actions incorporated in the Supplemental Agreement

The Office of the Monitor must conduct independent reviews of ADHS' efforts

Service Development

ADHS will retain the Human Services Research Institute (HSRI) as a consultant to determine

- The type, intensity, and amount of services
- Amount of services necessary to comply with the Exit Stipulation

ADHS with assistance from the RBHA will create three separate strategic plans

- Housing
- Vocational Services
- Needs of classmembers for substance abuse services

ADHS has submitted a FY2000 service expansion request of $32,169,00 to the Governor

ADHS will make its best efforts to secure approval for this request, consistent with ¶34 of the Exit Stipulation

ADHS will submit an amendment request to the Governor that are adequate when aggregated with other funds to fully implement the service capacity attachment and the housing, vocational and substance abuse strategic plans

To the extent that such expected funds decrease or are not realized ADHS will submit a future budget request to replace such funds

The service capacity attachment and the housing, vocational, and substance abuse strategic plans shall be implemented by June 30, 2002

Clinical Team and Case Management

ADHS will ensure that the RBHA prepares and submits to it a long-term plan for improving the clinical team process

- Structure
- Membership
- Functioning
- Roles and responsibilities of the clinical team

ADHS will ensure that the RHBA develops functional clinical teams with enhanced clinical leadership

ADHS will conduct regular reviews of the operations of the clinical teams and the cooperation, collaboration and coordination of clinical teams with service providers in the delivery of services to classmembers

Service Provider Network

ADHS shall ensure that the RBHA develops standards for the provider network.

RBHA to develop performance measures and sanctions for noncompliance with the provider standards

Compliance with ADHS' Rules and Monitoring

ADHS shall ensure:

- Compliance by the RBHA and the providers network with ADHS rules, Title 9, Ch.21, Article 1-5
- ADHS shall establish specific standards
- The parties shall agree on these standards which shall be filed with the Court and made a part of this Agreement.

As provided in ¶16 of appointment order the Monitor is authorized to monitor and make findings concerning compliance with all outstanding provisions of the Exit Stipulation and this Supplemental Agreement

The Monitor will fulfill this responsibility by conducting annual independent evaluations

Reviews will occur until the Monitor determines that the data generated from ADHS quality management system is substantially similar to the Monitor's independent reviews

The reviews shall determine at a minimum

- Whether the needs of classmembers are being met
- Whether the clinical teams are operating consistent with ADHS rules
- Whether the standards described in ¶32 for assessing compliance with ADHS rules are being met

ADHS will fund the Monitor's independent compliance reviews which shall not exceed $100,000

BEST EFFORTS

On March 1, 1999 a status conference was held with Judge Dougherty so that the Court could be apprised of the status of the department's budget request to the Governor and legislature

On April 2, 1999 another status conference was held as a follow-up to the March 1 conference.

The Court indicated at this conference that it would take a heightened role in the case in order to avoid litigation regarding best efforts and to not miss any further opportunities to obtain the necessary resources

Opportunities identified by the Court include:

- ADHS budget request for the second half of the 2000-2001 biennial budget
- The Task Force required by HB 2477
- The next FY 2002-2003 biennial budget
- The Legislative/Executive process for determining use of the tobacco settlement monies

At the direction of the Court, plaintiffs and ADHS submitted on May 26,1999 an agreement to engage in a collaborative process to secure resources and avoid the Court's intervention around best efforts.

STATEWIDE APPLICABILITY

While the lawsuit was brought in Maricopa County Superior Court and is clearly directed to the system and classmembers in Maricopa County. ADHS has always approached the broader aspects of Arnold on a statewide basis.

While some issues are peculiar to Maricopa County, the statutory mandates regarding mental health services that serve as the foundation for the plaintiffs' case apply statewide.

As a result, ADHS views all matters pertaining to services for the seriously mentally ill, unless clearly and specifically relevant only to Maricopa County, as having statewide application in terms of funding and program requirements.

The SMI Rules are applied on a statewide basis

Appendix E to Mental Health Task Force Report, November 30, 1999

Presentation to the
Task Force on Improving The Arizona Mental Health System
of the
Arizona State Legislature
by Anne Ronan
August 31, 1999

Good Morning. Thank you for the opportunity to review with you from the plaintiffs perspective the status of the Arnold v. ADHS litigation.

My name is Anne Ronan. I am an attorney with the Arizona Center for Disability Law, formerly part of Arizona Center for Law in the Public Interest. The Center represents a class of indigent persons with serious mental illness in Maricopa county in the Arnold v. ADHS litigation, commonly referred to as Arnold v. Sarn.

What I hope to do this morning is review with you a history of the case briefly, identify for the Task Force what the priorities are from the plaintiffs' perspective, and then answer some of the questions that were raised by Ron Smith's presentation last week.

At the time the lawsuit was filed, Charles Arnold was the Maricopa County public guardian. Many of the individuals for whom he was the appointed guardian were persons with serious mental illness. His wards were living on the street, in substandard board and care homes and regularly cycled through the state hospital, often discharged in stable condition to no services.

The lawsuit was filed to enforce the numerous state statutes the required services be provided in the community. The class of persons who are the plaintiffs in this case are the most fragile and vulnerable persons in our community.

Prior to filing the lawsuit, the legislature through the enactment of a series of progressive statutes had mandated that the Department of Health Services and the Arizona Counties provide a continuum of coordinated community mental health services to persons with serious mental illness who could benefit from those services.

ATTACHMENT 1

The lawsuit was filed in 1981, but the trial did not actually occur until 1985 and the Trial Courts judgment was not rendered until 1986. The trial court interpreted the state statutes to require the state and Maricopa county to develop the adequate community system.

The state and the county appealed. It was not until 1989 that the decision from the Arizona Supreme Court was issued. The Court found that in 1989 Arizona was the last among the states in providing services to the chronically mentally ill.

After the Supreme Court's ruling, the state and the county joined together in proposing a plan to develop the community mental health system. This plan is called the Implementation Plan or Blue Print. It is important to note that the plan did not originate with the court but came from the state and county. The plan developed by the state and county was in their opinion a competent plan to build the adequate system required by the legislature.

The plan was very ambitious. In the plan the state and county proposed that they would develop the infrastructure, the rules, the administrative capacity within ADHS and the services for what at that time was between 4,000 and 6,000 person with serious mental illness by 1995. Furthermore, the state would submit adequate budget requests annually to support the plan.

There was a great deal of progress made in the early years. Specifically, 104 of the commitments made in the original Implementation Plan were accomplished by 1995.

These accomplishments are quite significant and I would like to review them briefly.

Agency rules incorporated the principles for operating the community system.

Agency rules promulgated which describe

the eligiblity process,

assessment,

service planning,

right of classmembers,
appeal and grievance rights,
protections from unnecessary seclusion and restraint.

Agency rules were promulgated for provider agencies.

Agency rules defined the case manager roles and responsibilities.

Agency rules established the right and process for each individual to have a service plan which addressed their needs.

Ombudsman office was created.

The development of the service system was begun with the formation of clinical teams including the hiring of doctors, nurses, and case managers and the opening of clinic sites throughout the county.

Homeless outreach teams and jail diversion teams were established.

Inpatient services were established in the East and West valley.

In the first few years following the Implementation Plan the legislature appropriate significant increases in funding for services.

In addition, Arizona began receiving Title 19 [Medicaid] funding for the first time for mental health services. We were the last state to request and receive Title 19 funding for mental health. The population of eligible Title 19 persons in relation to the non-eligible Title 19 population has continued to grow and the funding for services for this population has grown. However, it is important to note that between 50 and 60% of persons with serious mental illness currently enrolled are not Title 19 eligible.

As Ron Smith reported in 1995 the state and county had not met the obligations in the Blue Print.

When we looked at where progress had not been made we found that many of the most vulnerable clients were not having their needs met. These included those still at ASH, or in substandard supervisory care homes, person who were homeless, in jail, or in and out of crisis and inpatient settings.

In 1995 the Implementation plan was replaced by the Stipulation on Exit Criteria and disengagement.

Our Priority in negotiating the Exit Stipulation was to make sure that those most vulnerable persons needs were met.

What was important from our perspective in entering in to the Stipulation was

-The state and county agreed to maintain the accomplishments they had already achieved

-The state agreed to meet the needs of four groups of classmembers

For each group the requirements were different

-People leaving ASH: the state must provide those supports and services necessary for the person to live in the community.
-People in substandard supervisory care homes: for ½ of the population the state must provide those supports necessary for the person to live in an appropriate setting.
-For a group described as the priority group: the state must provide for 80% all supports and services necessary. The four groups were:

persons who had been at ASH after 1993
persons who had been in substandard supervisory care after 1993
persons who had been a resident of 24 hour program after 1993

persons who were hospitalized 2x in a year or frequent user of crisis

-assumption is that this group is 3,000

For the balance of the class, the state had to substantially meet the needs of 80%.

It was our concern that the most fragile clients' needs be addressed first, and we believed that if the state could sustain a service system that met the needs of those class members it would have developed to a point where the court would no longer need to be involved.
In addition, we believed it was critical that the state develop an internal quality management plan and that the county develop programs to divert persons with serious mental illness from the jails.

Once again, in the first two years a significant effort was made to address these commitment.

However, in the fall of 1997 we reviewed the status of a number of priority clients and found that many of them were not doing well and, in fact, we believed the system development had lost ground. Some of the individuals who had left ASH were without the supports and services they needed to remain stable in their community setting.

In the spring of 1998 the Monitor's office oversaw an independent review which identified specific deficiencies in the care and services provided to the class. Following the review the state agreed to take some very specific steps which are contained in the supplemental agreement

-The specific deficiencies that the agreement addresses from our perspective are

-A detailed plan for developing and improving services to person with serious mental illness who have a co-occurring substance abuse problem. It is estimated that between 40 and 60% of the class have such cooccurring disorders.

Plan is done, in implementation stage.

-A detailed plan for developing housing and residential capacity

Plan is done, in implementation

-A detailed plan for developing employment and vocational services

Plan is done in implementation

-A specific statistically sound analysis of the amount and cost of additional services needed to meet the Exit Stipulation requirements.

Completed and approved by the state and court.

-A plan for improving clinical teams and case management services.

Outstanding

I believe that for the first time since the Court approved the Implementation Plan in 1991 all parties, the current plans, strategies and commitment of the state if funded and implemented will resolve this litigation.

Response to questions raised by Ron Smith presentation

First, Chairman Bush is correct that the reduction in the census at ASH was predicated on the development of services in the community. In order to sustain a reduction in census two things needed to occur. First, services needed to be developed for the over 100 plus residents at ASH who no longer needed inpatient restrictive environment. Second, services needed to be developed for person living in the community to keep them stable so they would never need to go to ASH.

The initial calculation was that on the average it would cost $55,000 per person to develop services for the residents of ASH. About $5 million was moved from the ASH budget when approximately $7 million was needed. Once ASH became back filled with forensic patients it was no longer possible to move the money to the community.

No money was available to do the second half of the job, that is to develop services to prevent long term hospitalization.

At the time we signed the Exit Stipulation the census at ASH was around 400. About 120 were individuals who had been there over a year. The balance almost 2/3 were there for between 30-60 days. The state believed and quite correctly that these individuals probably didn't need to have come to ASH, but services didn't exist to prevent their admission.

When we arrived at the 55 number we looked at the same criteria Mr. Silver suggested needed to be considered today.

Number of community residential beds

Effectiveness of acute inpatient treatment in community hospitals

Diversion efforts from hospitals and jails

Number of crisis stabilization beds

In states that had well developed community systems the need for long term beds was less.

With respect to supervisory care homes, first it is important to note that the homes we are talking about are not and were never licensed to provide mental health services. Secondly, the ones which took persons with serious mental illness were often health hazards and in very poor parts of town. The new licensing category which subsumed supervisory care, assisted living facilities, prohibits the admission of persons who require 24 hour supervision for behavioral health disorders.

We are working with the state on an incremental develop of budget requests which builds a set of core services for the most needing. Those include, housing, vocational/day, clinical services and medication.

I will take any questions.

Task Force on Improving the Arizona Mental Health System

[redacted]

[redacted]

- **Case Management**
  - *Current Case Management System*
- **Housing**
  - *Challenges*
  - *Current Housing System*
  - *Needs*
- **Summary**

2

ValueOptions

Low salaries

Low morale

Lack of education and training

High case manager/consumer ratios

High turnover

5

ValueOptions

Criteria for priority status

- *ASH*
- *Inpatient Hospitalization*
- *Frequent Crisis Calls*
- *24-hour Residential Care*
- *In jail with a major biological mental illness*

Exit Stipulation specifies that standards that apply to priority clients must be applied without any consideration of available resources.

Service planning for non-priority consumers with a SMI may take availability of resources into consideration.

6

ValueOptions

810 total staff (10/11/99)

23 Case Management sites

- *19 Adult*
- *4 Child/Adolescent*

54 Clinical Teams

- *47 SMI Adults*
- *7 Child/Adolescent*

343 Case Managers

Turnover rate:

- ***4.96%*** *(9/30/99)*

9

ValueOptions

Position	Number	Min. Credentials (as of 6/99)
Case Managers	343	Bachelors in Social Science
Lead Case Managers	54	Bachelors in Social Science
Clinical Care Coordinators/ Clinical Leads	13	Masters in Social Science
Nurses	70	Diploma in Nursing; Arizona Registered Nurse
Physicians	54	M.D. Degree Psychiatric Specialty

10

ValueOptions

Assist in monitoring, maintaining and modifying services

Assist in finding or developing necessary resources other than covered services to meet basic needs (i.e., food, shelter, clothing)

Identification and documentation of unmet service needs to be used by the organization in the expansion of existing services and development of new programs

Other activities as needed to enhance treatment effectiveness and compliance

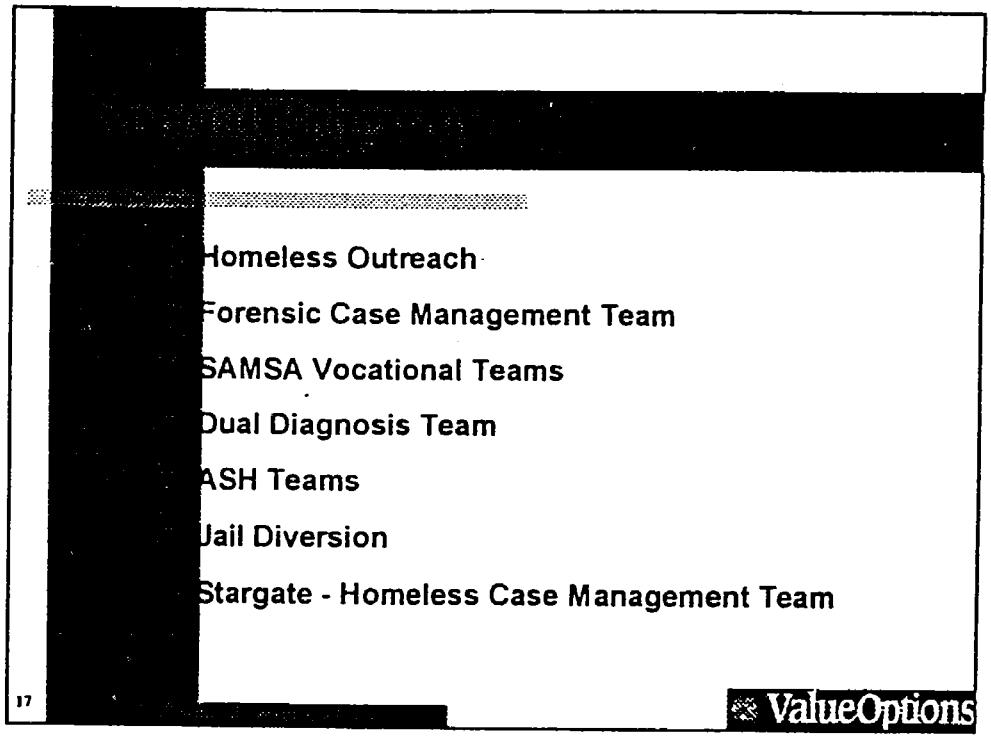
ValueOptions

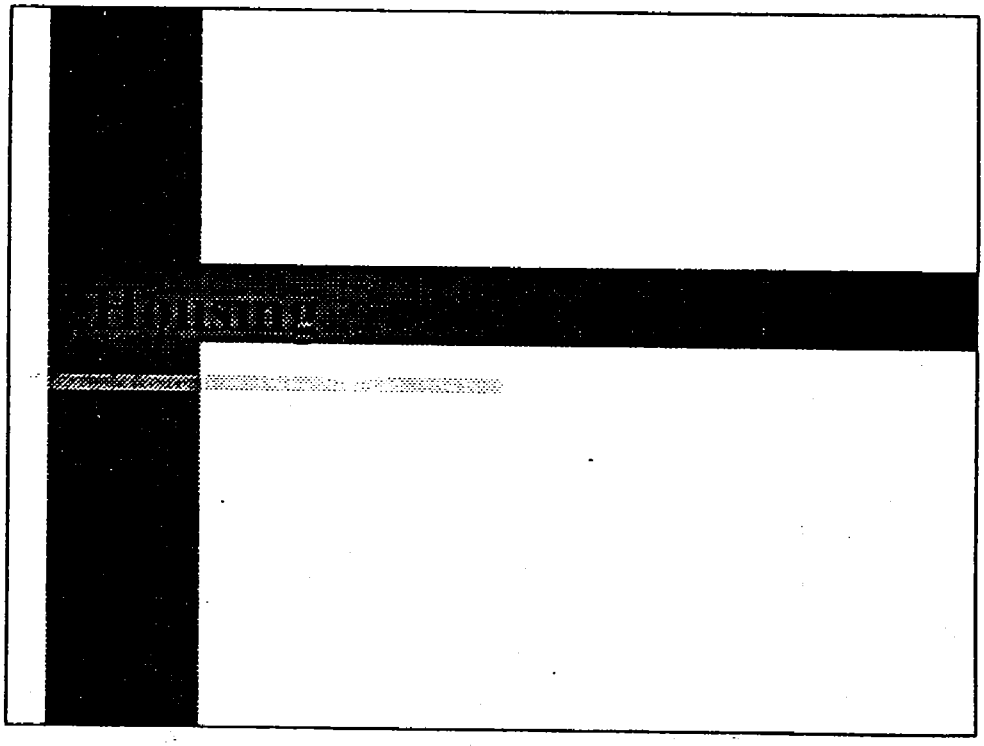
Phase determined based on Alfa score which includes measures of diagnosis and level of functioning and individual need.

Phase	No. of SMI Consumers *	Criteria	Minimum Case Mgmt. Contacts	CM Ratio
I	2449	Alfa Score including Diagnosis Level of Functioning Serious Medical Issues Individual Needs	CM ≥ 1 week MD ≥ 1 month	1/20
II	6622		CM ≥ 1 week MD ≥ 1 month	1/35
III	1892		CM ≥ 1 quarter MD ≥ 1 quarter	1/120

* As of August 21, 1999

ValueOptions


Homeless Outreach
Forensic Case Management Team
SAMSA Vocational Teams
Dual Diagnosis Team
ASH Teams
Jail Diversion
Stargate - Homeless Case Management Team
17
ValueOptions



Type of Programs	ValueOptions	Other RBHAs	State Total
HUD Supportive (SHP)	281	81	362
HUD Shelter + Care (S+C)	614	228	76
HUD 811	75	0	75
HUD Section 8	1000	597	1597
24-Hour Residential	212	225	316
Supervised Independent Living	339	496	835
Other	135	18	154
Total	2657	1736	4393

21

ValueOptions

Maricopa County

Type of Program	# of Units	Grant Recipient	Annual Cost	Expiration Date
S+C 114	114	ADOC	$ 913,500	June 2000
S+C 300	300	ADOC	$ 1,800,000	June 2000
S+C 200	200	ADOC	$ 1,301,900	June 2000
SHP HUD 125	125	ADOC	$899,400	June 2001
SHP Brookside (residential)	4	ADOC	$147,702	June 2001
SHP	6	ADOC	$145,000	2002
SHP NOVA (residential)	25	ABC	$1,019,935	Jan. 2000
SHP VILLAGE	23	ABC	$1,027,425	Dec. 1999
SHP HOU	20	ABC	$82,887	Jan. 2000
SHP SHANTI (residential HIV)	10	ABC	$58,026	Jan. 2001
SHP HRE (Domestic violence)	81	ABC	$ 616,884	Jan. 2000
SHP SWBH (residential HIV)	9	ABC	$ 31,190	April 2000
SHP H57	57	ABC	$281,553	Nov. 2000
SHP CASS	10	ABC	$ 32,953	June 2000
Total	984		$ 7,343,311	

22

ValueOptions

Additional Gaps

Additional gaps exist in the treatment and housing continuum, either because of lack of availability or lack of accessibility.

- *Persons leaving correctional facilities*
- *Persons with felony convictions or who are on probation and parole*
- *Persons who are in treatment for substance abuse and who have a corrections history are almost impossible to house.*

Transitional housing is difficult to find and expensive.

- *Housing that includes transition treatment interventions is not available in the current array.*

Other Populations

Consumers who have a dual diagnosis but not a SMI are forced to prove SMI status and downplay their substance abuse problems to obtain housing.

Families living in shelters who have a family member with behavioral health needs, whose condition is exacerbated by the transient nature of their housing.

Consumers living in inappropriate situations.

- *Non-recovery oriented environments*
- *Supervisory care homes per Arnold v. Sarn*
- *On the "Discharge Ready" list at ASH*
- *Living with inappropriate partners*

Housing for Individuals with A Serious Mental Illness

The Current Situation

- At a national level the provision of behavioral health and housing services to persons with mental health disabilities is at a critical juncture.
- According to the National Technical Assistance Center for State Mental Health Planning:

- "The erosion of affordable housing stock,
- diminishing federal funds,
- shifts in control from the federal level to the state and local levels,
- and the emergence of managed care

- Although these changes present significant challenges they also represent opportunities to reshape public policy and to improve consumers' access to safe, decent and affordable community-based housing
- by creating new partnerships that explore ways to pool resources across housing and service systems."

ARIZONA HOMELESS POPULATION

Seriously Mentally Ill	2930 individuals and family members	11% of total homeless
Dual Diagnosis	2400 individuals and family members	9% of total homeless
Chronic Substance Abuse	10,680 individuals and family members	40% of total homeless
HIV/AIDS	800 individuals and family members	3% of total homeless

Data Source :

1999 Continua of Care for the homeless
Maricopa County
Pima County
Balance of Arizona

Housing Continuum

ASH - - Inpatient Psychiatric Hospital - - 24 Residential -SIL - - Independent Living

HOUSING BY CATEGORY

Type of Programs	Value Options	CPSA	PGBHA	NARBHA	EXCEL	Total
HUD Supportive (SHP)	281	18	32	12	19	362
HUD Shelter + Care (S+C)	614	203	0	0	25	842
HUD 811	75	0	0	0	0	75
HUD Section 8	1000	565	0	12	20	1597
24 Hour Residential	212	225	36	20	35	528
Supervised Independent Living	339	426	28	32	10	835
Other	136	13	0	0	5	154
Total	2657	1450	96	76	114	4393

Currently in Maricopa County

- Nearly **2657** consumers receive housing assistance.
- However, there are few housing options available.
- Almost **1,200** of these units are HUD funded.

Housing options are concentrated either in

- Independent with and without wrap around support.
- Semi-independent living.
- 24-hour residential care.

Existing HUD Housing Programs for Maricopa County

Type of Program	# of Units	Grant Recipient	Annual Cost	Expiration Date
S+C	143	ADOC	$ 913,500	June 2000
S+C	280	ADOC	$ 1,800,000	June 2000
S+C	200	ADOC	$ 1,301,900	June 2001
SHP (2 projects)	133	ADOC	$ 948,300	June 2001
SHP	06	ADOC	$ 145,000	Dec 2002
SHP (5 projects)	133	ABC	$ 2,631,865	2000
Total	895		$ 7,739,665	

Funding Issues

- Arnold v Sarn Lawsuit

The State has the responsibility, under a court settlement agreement to:

- Aggressively apply for federal housing funds.
- Make best efforts to obtain alternative funding if HUD funding is not received.

HUD Continuum of Care Funding (Homeless Assistance/McKinney)

The projects for individuals with a serious mental illness are a **high percentage** of the currently funded HUD homeless projects in Maricopa County.

The **competition** for scarce HUD resources has caused substantial anxiety in the local homeless provider network.

- In calendar year 2000, 559 units of housing for individuals with a serious mental illness will require renewal funding.
- There is significant likelihood that **not all of the units will get refunded** in the current HUD competition.
- We project that as many as **93 to 280** Shelter Plus Care units may be at risk at an annual cost of **$600,000 – $1,800,000.**

- In calendar year 2001, an additional **325** units will be up for renewal funding at an estimated annual cost of **$2,300,000.**

Efforts to Obtain Renewal Funding

- The State will **continue to aggressively apply for renewal funding from HUD** sources, as required by Arnold v Sam.
- **Budget requests for unfunded units will be included in Commerce's annual budget** request (a request for complete renewal funding was included in Commerce's 1999 budget request).

- Continue to **work with HUD to change statutory language regarding mandated 5-year refunding of Shelter Plus Care projects**, asking for 1 to 5 year funding based on local priorities.
- Apply to HUD in 2000 for mainstream Section 8 certificates statewide to **transition current Shelter Plus Care recipients to permanent Section 8 rental assistance.**

- Work closely with HUD and the Arizona Congressional delegation to **shift the cost of Shelter Plus Care renewals from the Continuum of Care (competitive) account to the mainstream Section 8 (non-competitive) account.**

- Work closely with HUD and the Arizona Congressional delegation to **support the Administration's current budget request for 18,000 new incremental Section 8 vouchers for the homeless**, some of which would be allocated for the disabled, including individuals with a serious mental illness.

- **Continue to work with Public Housing Authorities and affordable housing developers, both for-profit and non-profit, to set aside a % of affordable housing units for this population.**

- **Continue to work with the Legislature to develop funding sources** for both existing housing units and for units to meet future housing needs of this population

Housing Gaps

- Other gaps exist in the treatment and housing continuum, either because of lack of availability or lack of accessibility.

- Persons leaving Correctional Facilities.

- Persons with felony convictions or who are on probation.

- Persons who are in treatment for substance abuse and who have a corrections history are almost impossible to house.

Transitional Housing

- Transitional housing for almost all populations is difficult to find and expensive.
- Transitional housing that combines transitional treatment interventions (preparation for de-institutionalization whether from treatment or correctional facility, or preparation for movement to a more independent living situation) is not systematically available in the current array.

Other Populations

- Consumers who have both psychiatric and substance abuse disorders but who do not qualify as individuals with a serious mental illness, are forced into trying to prove SMI status and to downplay their substance abuse problems in order to obtain help with housing.

- Families living in shelters who have an adult or child with behavioral health needs, whose condition is exacerbated by the transient nature of their housing situation.

Consumers Currently Housed in Inappropriate Living Situations

- Living in non-recovery-oriented environments.
- Supervisory Care Homes per Arnold vs. Sam.

- Living with inappropriate partners.
- On the "discharge ready" list at the Arizona State Hospital.
- Persons who have been previously evicted or who fail rental applications.

Behavioral Health Funded Housing

Psychiatric Hospital

A behavioral health service agency that provides a structured treatment setting with daily 24-hour supervison, on-site medical care and an intensive treatment program.

24 Hour Residential Treatment Center

A behavioral health service agency that provides a structured residential treatment setting with 24-hour supervision and counseling or other therapeutic activities for clients who do not require on-site medical services.

Supervised Independent Living Facility

Services provided to SIL clients within the facility may include behavior management, counseling, medication monitoring and other services that allow the client to maintain independent living.

Clients do not receive 24-hour supervision but are monitored based on their individual functional level.

Expenditures for room, board utilities and other related living costs are not Title XIX reimbursable.

Supportive Housing Assistance

Subsidy payments to assist a client with rent, utility or other living expenses that allow the client to live independently in a safe, healthy environment that meets the client's needs. This is not a Title XIX reimbursable service.

Clients may receive "wrap around services" such as behavioral management, counseling, medication monitoring and other services that allow the client to maintain independent living.

HUD Housing Programs in Existence in Arizona

SHELTER PLUS CARE PROGRAM

HUD rental assistance housing program specifically to provide permanent supportive housing for homeless persons with a disability. HUD provides funding for the rental assistance to program participants and the local program provides match funds for supportive services equal to the amount of the HUD rental assistance provided.

SUPPORTIVE HOUSING PROGRAM

HUD homeless assistance program that provides funding for transitional and permanent housing, including supportive services, for any homeless subpopulation. Matching funds requirements vary depending on the type of program being operated.

SECTION 811 HOUSING PROGRAM

HUD housing development program specifically designed for persons with disabilities. HUD provides capital advances to non-profit sponsors for the development of small housing projects and provides housing operating subsidies to run the facilities. Local sponsors must make arrangements for the provision of supportive services to the disabled persons being served by the project.

SECTION 8 HOUSING PROGRAM

HUD's principal housing program to provide rental assistance for low-income persons. Section 8 has several components including: tenant-based rental assistance administered by local public housing authorities (PHAs); and, project-based rental assistance tied to specific private rental properties. HUD has recently set aside specific numbers of housing units to assist disabled populations through the Mainstream Program, which can be administered by PHAs and, in some cases, by non-profit organizations.

Housing Development Resources

HOME Investment Partnership

HUD funds administered by local governments to provide a range of affordable housing activities for low-income persons, including disabled populations.

Housing Trust Fund

State program to assist in the development of affordable housing projects for low-income persons in Arizona.

Community Development Block Grant

HUD funds administered by local governments. Can be used to provide funding for the development of housing for low-income disabled persons.

Low Income Housing Tax Credits

Tax credits made available to developers of affordable housing for low-income persons. Tax credits are sold to investors to provide substantial portions of the capital necessary to development rental units. In Arizona, special priority is given to projects serving very low-income and special needs populations.

Tax Exempt Bonds

Tax exempt bonds can be issued to provide development capital for affordable rental housing projects. Bonds can be used in conjunction with Low Income Housing Tax Credits.

Appendix H to Mental Health Task Force Report, November 30, 1999

REPORT FOR:

ARIZONA SERVICE CAPACITY PLANNING PROJECT

July 30, 1999

HUMAN SERVICES RESEARCH INSTITUTE

Arnold V Sarn Service Capacity Plan

1.0 Background

This study of the mental health service needs of persons with serious mental illness in Maricopa County was commissioned by the Arizona Division of Behavioral Health Services (ADBHS). The ADBHS commissioned the study pursuant to the ongoing provisions of the *Arnold v Sarn* agreement and the direction of the Court Monitor. The Human Services Research Institute (HSRI) provided the independent expert services required by the study. HSRI employed resource allocation planning methods used in over a dozen other states (Leff, 1998). These methods combine clinical expertise with statistical methods and computer implemented simulation technology developed in a collaboration between HSRI and colleagues at the Massachusetts Institute of Technology (Leff, Graves, Natkins, & Bryan 1985; Leff, Dada, & Graves 1986). HSRI used data on client functional status, service needs and outcomes, and service costs collected in Arizona and other states. As part of the planning process, the data from Arizona and other states was validated by checks for completeness and consistency. As needed, the data was adjusted to reflect particular features of the Arizona mental health system and current labor market conditions. The specific tasks required by the study, carried out over a period of six months, are described below.

2.0 Objectives

The objectives of the independent study were to estimate the types, amounts, and costs of mental health services needed by persons with serious mental illness in Maricopa County.

The tasks involved in the study are listed below and discussed in sections 3-8.

- Assess data quality of ADBHS management information system data.
- Estimate distribution of persons by functional level based on Client Intake and Assessment files.
- Determine and define services to be provided to clients in the ADBHS system based on taxonomies from Arizona and other states.
- Estimate service unit costs based on data from Arizona and other states.
- Prescribe types and amounts of services for seriously mentally ill persons at different functional levels using data and expert judgements from Arizona and other states.
- Estimate annual service system costs, taking into account estimated service needs and unit costs and consumer outcomes.

The clinical principles underlying the study were that persons with severe mental illness should be provided treatments that:

- Ensure consumer and community safety;
- Are least restrictive;
- Are flexible and change as needs change;
- Promote maximum consumer functioning, empowerment, and recovery;
- Are the most cost-effective means for attaining the above ends.

3.0 Assess Data Quality

HSRI inspected ADBHS data for 1998 from the perspectives of the face validity of client assessment instruments used, the reliability and validity reported in the literature for the Colorado Client Assessment Record (the major assessment instrument employed by ADBHS), the completeness of data, the comparability of the data to data from other states and from an earlier Arizona project, and the construct validity of the client assessment data. The latter task involved developing algorithms for assigning persons to levels of functioning and exploring the association of these measures with other measures of functioning, clinical status, and problems. After study, HSRI judged the quality of the data available from the ADBHS to be adequate for the planning process. Materials resulting from these activities are provided in Attachment B.

4.0 Estimate Functional Level Distribution

Consumers were categorized into six functional level groups using a framework suggested by the Resource Associated Functional Level Scale (RAFLS) (Leff, Swartz, Cohler and Schlesinger, 1985). The RAFLS categories are described in detail in Attachment B. The RAFLS is a single dimension global scale that has seven levels, six of which indicate the need for mental health services. Lower scores indicate higher levels of dangerousness, more disruptive symptomatology, less ability to cooperate in one's own care, fewer independent living skills, less stress tolerance, and more need for mental health services. This scale has been shown to have characteristics that are consistent with the criteria listed above and the objectives of defining priority clients and developing practice guidelines. The RAFLS levels have acceptable inter-rater reliability, face validity and construct validity for clients differing in clinical and sociodemographic characteristics. Importantly, RAFLS levels can be related to service prescription and outcome information collected by HSRI.

Several algorithms for assigning consumers to functional groups were considered and reviewed by the planning process participants. A list of the planning process participants can be found in Attachment A. These algorithms were reviewed in terms of their logical coherence, relationships to other measures, and similarity to data from other states. Distributions were developed for consumers who received assessments prior to

1998 (the "snapshot population") and for persons who received intakes in 1998 (the "arrival population"). An algorithm based on actual ADBHS data was selected by HSRI. The distributions based on the algorithm are described below and on the following page for the snapshot and arrival estimates.

TABLE 1. Estimated Snapshot Functional Level Distribution: Percents and Number of Consumers in Planning Population

RAFLS LEVEL	%	Number
1 Dangerous Dangerous to self or others and unwilling or unable to cooperate in own care. Requires 24-hour supervision.	7	840
2 Unable to Function, Current psychiatric Symptoms (Acute) Unable to function, current psychiatric symptoms (acute) result in behavior that is seriously disruptive or at risk.	12	1428
3 Lacks ADL/Personal Care Skills Lacks ADL/personal care skills; symptoms no longer result in behavior that is seriously disruptive or at risk.	29	3516
4 Lacks Community Living Skills Able to carry out ADL personal care skills but lacks community living skills	13	1536
5 Needs Role Support and Training Can perform role functions minimally with frequent support and training	18	2124
6 Needs Support/Treatment to Cope with Extreme Stress or Seeks Treatment to Maintain or Enhance Personal Development Can perform role functions adequately	21	2556
Total	100	12000

TABLE 2. Estimated Arrival Functional Level Distribution: Percents and Annual Numbers of Consumers in Planning Population

RAFLS LEVEL	%	Number
1 Dangerous Dangerous to self or others and unwilling or unable to cooperate in own care. Requires 24-hour supervision.	9.1	224
2 Unable to Function, Current psychiatric Symptoms (Acute) Unable to function, current psychiatric symptoms (acute) result in behavior that is seriously disruptive or at risk.	21.4	527
3 Lacks ADL/Personal Care Skills Lacks ADL/personal care skills; symptoms no longer result in behavior that is seriously disruptive or at risk.	29.8	734
4 Lacks Community Living Skills Able to carry out ADL personal care skills but lacks community living skills	15.8	389
5 Needs Role Support and Training Can perform role functions minimally with frequent support and training	14.1	347
6 Needs Support/Treatment to Cope with Extreme Stress or Seeks Treatment to Maintain or Enhance Personal Development Can perform role functions adequately	9.7	239
Total	99.9	2463

5.0 Determine and Define Services

In consultation with the planning participants, HSRI developed a list of services and service definitions judged necessary for persons in the planning population. These services were suggested by reviews of services provided in Arizona and other states, consideration of the scientific literature on evidenced based mental health services, and the literature on consumer and family preferences (Meta-Analysis of Studies on

Community Support Program Services,1999; Schizophrenia PORT Treatment recommendations,1996). The service domains covered included: residential, emergency services, hospital and crisis, treatment, outpatient treatment, rehabilitation and support. Services were selected that were consistent with the scientific evidence and the clinical principles cited above that services should ensure consumer and community safety, be least restrictive, respond flexibly to changes in need, promote functioning, empowerment, and recovery, and be cost-effective.

The final list of 35 services, organized by domain is presented below. Other materials related to this activity are presented in Attachment C.

Table 3. List of Services in Needs Assessment By Service Domain

Residential	Outpatient Treatment (Cont.)
1. Intensive Staff/ Supervision	18. Group Psychotherapy
2. Moderate Staff/ Supervision	19. Family Psychotherapy
3. Minimum Staff/ Supervision	20. Therapeutic Supervision
4. Independent Living w/ Housing Subsidy	21. Outpatient Detoxification
5. Independent Living w/o Housing Subsidy	22. Substance Abuse Counseling
6. Specialized Residential	23. Methadone Maintenance Clinic
Emergency	**Rehabilitation**
7. Crisis Outreach	24. Psychosocial Rehabilitation
8. Crisis Emergency Walk-In	25. Consumer Operated Services
9. Crisis Residential	26. Vocational Assessment
10. Respite Care	27. Supported Employment
Hospital	28. Support Education & Other Educational Services
11. Inpatient - Specialty/State	**Support**
12. Inpatient - General	29. ACT
13. Inpatient - Forensic	30. Intensive Clinical Services
14. Inpatient - Detoxification	31. Medication Management
Outpatient Treatment	32. Protection & Advocacy
15. Evaluation (Diagnosis)	33. Client Transportation
16. Court Ordered Evaluation	34. Family Psychoeducation
17. Individual Psychotherapy	35. Friend Advocacy

6.0 Estimate service unit costs based on data from Arizona and other states.

Unit service costs for 18 states were examined. For data prior to 1998, an inflation rate equation was utilized to provide updated costs. This equation was based on data from the Bureau of Labor Statistics's Consumer Price Index – for Medical Care Services. For some services, unit costs were calculated using information provided and reviewed by the planning process participants relating to staffing patterns and assumptions about amounts of service to be delivered. In addition, whenever possible, unit cost estimates were compared with unit cost estimates in the published literature on services for persons with severe mental illness. The final service unit costs estimated by HSRI and the planning participants are listed on the following page.

TABLE 4. Unit Costs Estimated for Services in Needs Assessment

RESIDENTIAL	UNIT	UNIT COST
1. Intensive Staff/ Supervision	Days	$250.00
2. Moderate Staff/ Supervision	Days	$200.00
3. Minimum Staff/ Supervision	Days	$90.00
4. Independent Living w/ Housing Subsidy	Days	$11.51
5. Independent Living w/o Housing Subsidy*	Days	
6. Specialized Residential	Days	$275.00
EMERGENCY SERVICES		
7. Crisis Outreach	Hours	$115.00
8. Crisis Emergency Walk-In	Hours	$166.00
9. Crisis Residential	Days	$285.00
10. Respite Care	Days	$132.00
HOSPITAL & CRISIS		
11. Inpatient - Specialty/State	Days	$285.00
12. Inpatient – General	Days	$440.00
13. Inpatient – Forensic	Days	$285.00
14. Inpatient – Detoxification	Days	$150.00
TREATMENT		
15. Evaluation (Diagnosis)	Hours	$110.00
16. Court Ordered Evaluation	Hours	$110.00
17. Individual Psychotherapy	Hours	$85.00
18. Group Psychotherapy	Hours	$20.00
19. Family Psychotherapy	Hours	$80.00
20. Therapeutic Supervision	Hours	$25.00
21. Outpatient Detoxification	Hours	$75.00
22. Substance Abuse Counseling	Hours	$75.00
23. Methadone Maintenance Clinic	Week	$75.00
REHABILITATION		
24. Psychosocial Rehabilitation	Hours	$11.00
25. Consumer Operated Services	Hours	$5.00
26. Vocational Assessment	Hours	$60.00
27. Supported Employment	Hours	$60.00
28. Support Education & Other Educational Services	Hours	$30.00
SUPPORT		
29. ACT	Hours	$123.00
30. Intensive Clinical Services	Hours	$90.00
31. Medication Management	Hours	$64.00
32. Protection & Advocacy	Hours	$22.50
33. Client Transportation	Hours	$10.00
34. Family Psycho-education	Hours	$60.00
35. Friend Advocacy	Per person	$83.00

* Independent Living w/o Housing Subsidy does not have an associated cost because the assumption is that housing costs are paid by other sources.

7.0 **Prescribe types and amounts of services for seriously mentally ill persons at different functional levels using data from Arizona and other states, the scientific literature, and expert judgements.**

Service prescriptions (types and amounts of service) for functional groups were estimated to achieve the goals embodied in the clinical principles cited above. These recommendations were based on prescriptions from a previous Arizona study, other states (e.g., Rhode Island and Western Massachusetts), expert judgement, information about the current Arizona system, and the scientific literature. For each functional level the percent of consumers that should receive a service and the average amount that recipients should be delivered monthly were determined. The final prescriptions per functional level were determined by HSRI in consultation with the planning group. These prescriptions were tested against data from other states, the professional literature, and earlier studies in Arizona to confirm their validity and reliability.

Table 5 provides an example of service prescriptions for the residential services domain. When these two columns are multiplied together (average percent per month and average amount per month), they produce the average monthly utilization per person in the planning population. Attachment D contains the final prescriptions for Arizona along with the associated unit costs.

TABLE 5. Example of Service Prescriptions

			Average % Per Month						Average Amount Per Month					
	Unit	Unit cost	1	2	3	4	5	6	1	2	3	4	5	6
RESIDENTIAL														
Intensive Staff/Supervision	Days	$250	10	5	30				30.42	30.42	30.42			
Moderate Staff/Supervision	Days	$200	10	2.5	15	15	10		30.42	30.42	30.42	30.42	30.42	
Minimum Staff/Supervision	Days	$90			20	25					30.42	30.42		
Indep. Living w/subsidized housing	Days	$11.51	35	50	25	30	45	45	30.42	30.42	30.42	30.42	30.42	30.42
Indep. Living w/o sub. Housing	Days		25	40	25	25	45	55	30.42	30.42	30.42	30.42	30.42	30.42
Specialized Residential	Days	$275	20	2.5	7	5			30.42	30.42	30.42	30.42		

8.0 Estimate annual service system costs, taking into account estimated service needs and unit costs and consumer outcomes.

After estimating the information described above (numbers of persons to be served categorized by functional level, types and amounts of services needed, and service unit costs), HSRI entered this information into a dynamic computer simulation. This simulation estimates service utilization and expenditures for a comprehensive, full capacity service system, taking into account projected service needs and outcomes. Outcomes were estimated drawing on evaluation research conducted in Arizona (Leff, 1998), and other states (Hargreaves, 1986; Leff, Graves, Natkins, & Bryan 1985). HSRI then explored a variety of planning options with the participants in the planning process. The estimated service system costs for a fully funded non-dynamic model and a dynamic model assuming client improvement given a comprehensive, full capacity service system are summarized in Table 6, on the following page. Column 2 shows costs for all clients at 100% of costs. Column 3 presents costs for all clients adjusted according to formulas provided by the parties to meet the court orders and specifically to meet the Stipulation on Exit Criteria and Disengagement in *Arnold v Sarn*.

Table 6. Costs for Desired Service System for All Clients at 100% of Estimate and According to Exit Stipulation

Column 1: Type of Cost	Column 2: Costs for All Clients- 100% of Estimate	Column 3: Costs Adjusted According to Exit Stipulation[1]
Full Funding per HSRI Model	$467,207,838	N/A
Client Movement Model (Direct Service)	$370,015,798	$269,050,475
Medications	$33,635,375	$24,457,371
Administration at 8%	$32,292,094	$23,480,628
Total Cost[2]	$435,943,267	$316,988,474
Total Cost Per Person	$30,576	$22,233

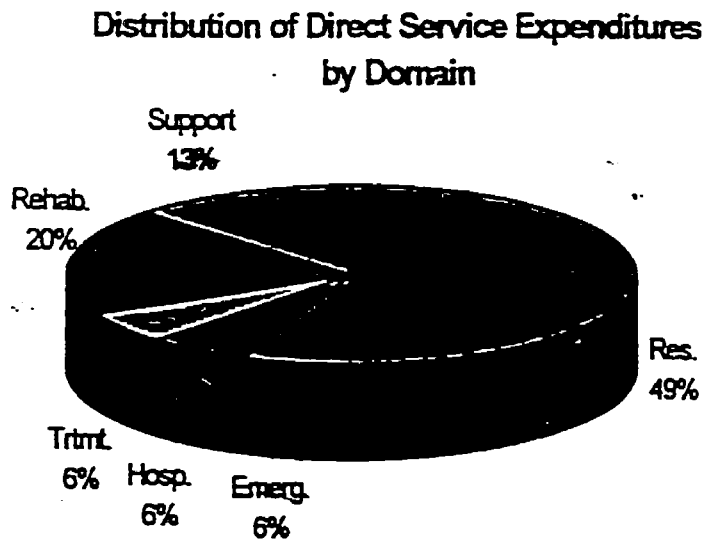
This simulation assumed that consumers' service needs are fully met and that meeting these needs improves outcomes for most persons. Medication costs were provided by the planning participants. Administrative costs were calculated at 8% of direct service costs. This rate was supplied by the ADBHS. Other materials related to this activity are presented in Attachment E.

[1] The 1996 Stipulation on Disengagement establishes the remaining obligations in *Arnold v Sarn*.

[2] The actual amount of new money needed will be less than these totals, depending on use of existing funding and resources.

Figure 1 shows the projected distribution of year 1 expenditures for the full capacity client movement model by service domains. This figure shows that the bulk of expenditures are directed at housing, rehabilitation, and support. This expenditure distribution is reflective of the clinical principles that informed the planning process which emphasize consumer and community safety, least restrictive environment, flexible services, and consumer recovery and independence.

FIGURE 1. Year 1 Distribution of Expenditures by Service Domains



9.0 Conclusions

This plan for a comprehensive, full capacity mental health system developed for Arizona is based on the best information and planning technology currently available. The plan is very explicit about the types of persons to be served, the types and amounts of services needed, the consumer outcomes to be expected, and the probable costs of the services. These estimates can and should be tested as the plan is implemented. To the extent there are variances from theses estimates, the plan can be revised using new information.

A comprehensive, full capacity mental health system will cost substantially more than is currently spent on mental health services in Arizona. However, if implemented, the direct service costs for the planning population can be expected to decrease

significantly as many persons improve in functioning and some reach the point that they no longer need regular services from the public mental health system.

In this context, it is important to note that the projections presented assume a "frictionless" system in which services can be changed rapidly in response to changes in consumer needs. Real systems experience friction and should be expected to change more slowly than our model projects.

The plan addresses the monetary resources required by the plan. It is important to note that implementing the plan will also require well-trained and skilled "front-line" staff who can deliver the proposed services in the manner required. Programs will be required to recruit, train, and retain staff for the services planned. Moreover, the manner in which services are delivered, not just the types and amounts of services delivered, should be monitored to ensure that the services delivered have fidelity to the service models referenced in the service definitions. If service fidelity drifts away from desired models, refresher training will be necessary.

Finally, due to constraints on dollar and other resources, it is likely that the system planned must be implemented incrementally. It should be remembered that the service cost projections assume a fully implemented system. If consumers receive only a portion of the services planned, they will realize only a portion of the outcomes. Thus, reductions in cost projected from increased independence may not be achieved during any start-up period. An alternative strategy to providing partial services to all consumers in the target population would be to provide complete services to only some consumers, selected because they are priority clients or on some other basis. Under this strategy, the consumers provided comprehensive services should receive the full benefits of the service packages. This approach also permits the strategy to be tested and refined on a smaller number of persons before it is adopted for all consumers.

REFERENCES

Hargreaves, WA. Theory of Psychiatric Treatment Systems. Archives of General Psychiatry, 1986, (43):701-705.

Leff, HS, Dada, M, Graves, S. An LP planning model for a mental health community support system. *Management Science* 1986;32:2(Feb):139-155.

Leff, HS, Graves, S, Natkins, J, Bryan, J. A system for allocating mental health resources. *Administration in Mental Health* 1985;13:1(Fall):43-68.

Leff, HS. A Mental Health Service System Model for Managing Mental Health Care: Theory, Application, and Research. Working Paper of the Evaluation Center@HSRI 1998.

Leff, HS, Swartz, BD, Cohler,MR, Schlesinger, M. An initial exploration of functional level and length of psychiatric hospitalization in four different hospitals: relationships and implications for a prospective payment system. Prepared for the National Institute of Mental Health, 1985.

Leff, HS, Zarin, A. and Colleagues. Meta-Analysis of Studies on Community Support Program Services. Report to The Center for Mental Health Services, The Evaluation Center@HSRI, 1999.

Schizophrenia PORT Treatment Recommendations. Agency for Health Care Policy and Research and the National Institute for Mental Health, 1996.

Attachment A

Planning Process Participants

- Aimee Schwartz, M.D., Medical Director, Division of Behavioral Health Services, Arizona Department of Health Services
- Ronald Smith, Assistant Director, Division of Behavioral Health Services, Arizona Department of Health Services
- Linda Glenn, Superior Court of Arizona, Office of the Monitor Court Appointed Monitor
- Steven J. Schwartz, Foundation for Justice - plaintiffs' counsel
- Cathy E. Costanzo, Foundation for Justice - plaintiffs' counsel
- Stephen Leff, Ph.D., Senior Vice President, HSRI
- Laura Greene, MSW, Research Associate, HSRI

Attachment B

DATA FILES

Arizona Department of Health Services
Behavioral Health Services

FY98	Over 18 Rec'ds	Over 18 Distinct Count	Assessment A Rec'ds	Assessment A Distinct Count	Assessment B Rec'ds	Assessment B Distinct Count	Both Assessments Rec'ds	Both Assessments Distinct Count
SMI Clients (Maricopa County)	13,512	13,183	20,795	12,434	18,853	11,143	36635	11,094

Functional Levels
based on 12,000 clients

RAFLS LEVEL	HSRI1	
	%	N
1	7	840
2	11.9	1428
3	29.3	3516
4	12.8	1536
5	17.7	2124
6	21.3	2556
total	100	12000

RESOURCE ASSOCIATED FUNCTIONAL LEVEL SCALE (RAFLS)

Circle the number of the functional level that best describes this patient's current level of functioning. Rate actual functioning even if functioning is dependent o medication or some other form of treatment.

(1) Dangerous

Dangerous to self, others, or property of value. Unable or unwilling to control violent, aggressive or escape seeking behavior. Requires continuous (24-hour) supervision, high staff/patient ratio, locked or limited access facility.

(2) Unable to Function. Current. Psychiatric Symptoms (Acute)

Symptoms result in behavior that is seriously disruptive or at risk, and/or prevent role functioning. Examples of symptoms: lack of reality testing, hallucinations or delusions, impaired judgement, impaired communication, or manic behavior. If suicidal or homicidal, is able/willing to control impulses with assistance. May be able to carry out some activities of daily living. Requires continuous supervision, moderate staff/patient ratio, limited-access facility.

(3) Lacks ADL/Personal Care Skills

Symptoms no longer result in behavior that is seriously disruptive or at risk. (Nuisance behaviors should not be considered seriously disruptive or dangerous). Lacks sufficient ADL and/or personal care skills to carry out role functions. Skills lacking because: 1) never mastered, or 2) atrophied through disuse from creation of extreme dependency, neglect, lack of motivation. Requires continuous (24-hour) prompting, skill-training, and encouragement. Moderate staff/patient ratio needed.

(4) Lacks Community Living Skills

Able to carry out ADL personal care skills. Role functioning impaired by lack of community living skills or motivation to perform. Community living skills include: housekeeping, money management, using public transportation, ability to engage in competitive employment, maintaining interpersonal contacts. Requires regular and substantial (e.g., 2 or more hours per day), but not necessarily continuous training, prompting and encouragement.

(5) Needs Role Support and Training

Can perform role functions, at least minimally, in familiar settings and with frequent support to deal with the ordinary stresses of everyday life; e.g., can perform housekeeping tasks, although may need the regular assistance of a roommate, homemaker-aid, etc., or can work outside of sheltered situations with an understanding employer or on-site support or counseling. Becomes dysfunctional under the stresses associated with the frustrations of everyday life and novel situations. Requires frequent (e.g., weekly) information, encouragement, and instrumental assistance.

(6) Needs Support/Treatment to Cope with Extreme Stress or Seeks Treatment to Maintain or Enhance Personal Development

Can perform role functions adequately except under extreme or unusual stress. At these times, the support of natural or generic helpers such as: family, friends, clergy or physician, is not sufficient. Mental health services are required for the duration of stress; or performs role functions adequately, but seeks mental health services because of feelings of persistent dissatisfaction with self or personal relationship. Intensity and duration of treatment can vary.

(7) System Independent

Can obtain support from natural helper or generic services. Does not require or seek mental health services.

CCAR TO RAFLS ALGORITHM

RAFLS	ARIZONA (CCAR)
Functional Level 1 Dangerous to self, others, or property of value. Unable or unwilling to control violent, aggressive or escape seeking behavior. Requires continuous (24 hour) supervision, high staff/patient ratio, locked or limited access facility.	Socio Legal 41-50: Serious disruption of socio-legal functioning. Actions are out of control without regard for rules and law. Seriously disruptive to society and/or pervasively dangerous to other's bodily safety. In confinement or imminent risk of confinement due to illegal or antisocial activities. Imminent danger to others or property.
Functional Level 2 Symptoms result in behavior that is seriously disruptive or at risk, and/or prevent role functioning. Examples of symptoms: lack of reality testing, hallucinations or delusions, impaired judgement, impaired communication, or manic behavior. If suicidal or homicidal, is able/willing to control impulses with assistance. May be able to carry out some activities of daily living. Requires continuous staff/patient supervision, moderate ratio, limited access facility.	Mood 41-50: Severe disruption or incapacitation by feelings of distress. Unable to control emotion which affects all of the person's behavior and communication. Lack of emotional control renders communication difficult even if the person is intellectually intact. Emotional responses are highly inappropriate most of the time. Changes from high to low moods make person incapable of functioning. Constantly feels worthless with extreme guilt and anger. Depression and/or anxiety incapacitates person to a significant degree most of the time. Thought 41-50 Incapacitated due to impaired thought and thinking processes. Severe to profound mental retardation and/or extreme disruption or absence of rational thinking. Delusions. Frequent hallucinations or illusions that the person cannot distinguish from reality. Communication is extremely difficult. Unable to function independently. Severely disoriented most of the time. Significant loss of memory
Functional Level 3 Symptoms no longer result in behavior that is at risk or dangerous. (Nuisance behaviors should not be considered seriously disruptive or dangerous). Lacks sufficient ADL and/or personal care skills to carry out role functions. Skills lacking because: 1) never mastered, or 2) atrophied through disuse from creation of extreme dependency, neglect, lack of motivation. Requires continuous (24 hour) prompting, skill training, and encouragement Moderate staff/patient ratio needed.	Self Care: 41-50 Severe disruption of ability to independently meet or arrange for the majority of basic needs by legitimate or illegitimate means. Unable to care for self in safe sanitary manner. Housing, food and/or clothing must be provided or arranged for by others. Incapable of obtaining any means of financial support. Totally dependent on others for transportation. Thought: 31-40 Frequent or consistent interference with daily life due to impaired thinking. Mild to moderate mental retardation and/or frequent distortion of thinking due to emotional and/or other personal factors. Frequent substitution of fantasy for reality, isolated delusions, or infrequent hallucinations. Poor judgement is characteristic at this level. Mild to moderate retardation, but can function with supervision. Delusions and/or hallucinations interfere with normal daily functioning. Frequently disoriented as to time, place, or person. Unable to remember recent or past events.

Functional Level 4 Able to carry out ADL personal care skills. Role functioning impaired by lack of community living skills or motivation to perform. Community living skills include: housekeeping, money management, using public transportation, ability to engage in competitive employment, maintaining interpersonal contacts. Requires regular and substantial (e.g., 2 or more hours per day), but not necessarily continuous training, prompting, and encouragement.	Self care: 31-40 Occasional major or frequent disruption of ability to obtain or arrange for at least some basic needs. Includes denial of need for assistance or support, or meeting needs wholly through illegitimate means. Unable to maintain hygiene, diet, clothing, and prepare food. Considerable assistance required in order to obtain housing, food, and/or clothing. Consistent difficulty in arranging for adequate finances. Usually depends on others for transportation. May need assistance in caring for self. Socio Legal: 31-40 Occasional major or frequent disruption of socio-legal functioning. Conforms to rules only when more convenient or profitable than violation. Personal gain out-weighs concern for others, leading to frequent and/or serious violation of laws and other codes. May be seen as dangerous as well as unreliable. Frequent contacts with the law. On probation, or paroled after being incarcerated for a felony. Criminal involvement. Disregard for safety of rights of others. So disruptive or belligerent as to make ordinary social interaction impossible. Role performance:41-50 Severe disruption of role performance due to serious incapacity or absent motivation. Attempts, if any, at productive functioning are ineffective and marked by clear failure. Client not employable. Living situations must be managed by others. Interpersonal: 41-50 Serious disruption of interpersonal relationships or incapacitation of ability to form relationships. No close relationships; few, if any, casual associations which are satisfying. Socially extremely isolated. Argumentative style or extreme dependent style make work relationships virtually impossible. Family: 41-50 extensive disruption of family unit. Relationships within family are either extremely tenuous or extremely destructive. Not capable of forming primary relationships. Unable to function in parenting role. Abusive or disturbed.
Functional Level 5 Can perform role functions, at least minimally, in familiar settings and with frequent support to deal with the ordinary stresses of everyday life; e.g., can perform housekeeping tasks, although may need the regular assistance of a roommate, homemaker-aid, etc., or can work outside of sheltered situations with an understanding employer or on-site support or counseling. Becomes dysfunctional under the stresses associated with the frustrations of everyday life and novel situations. Requires frequent (e.g., weekly) information, encouragement, and instrumental assistance.	Role Performance:31-40 Occasional major or frequent disruption of role performance. Contribution in the most relevant role is clearly marginal Client seldom meets usual expectations and there is a high frequency of significant consequences. i.e. firing, suspension. Frequently in trouble at work, or frequently fired. Home chores ignored, some bills defaulted. Family: 31-40 Occasional major or frequent minor disruption of family relationships. Family does not function as a unit. Frequent turbulence and occasional violence involving adults or children. Turbulent primary relationship or especially disturbing break up. Adult rage and/or violence directed toward each other or children. Interpersonal: 31-40 Occasional major or frequent disruption of interpersonal relationships. May be actively disliked or virtually unknown by many with whom there is daily contact. Relationships usually fraught with difficulty. Has difficulty making and keeping friends such that has few friends or tenuous, strained relationships. Generally rejects or is rejected by coworkers; tenuous job relationships.

Functional Level 6 Can perform role functions adequately except under extreme or unusual stress. At these times, the support of natural or generic helpers such as: family, friends, clergy, or physician, is not sufficient. Mental health services are required for the duration of stress; or performs role functions adequately, but seeks mental health services because of feelings of persistent dissatisfaction with self or personal relationships. Intensity and duration of treatment can vary.	All others
Functional Level 7 Can obtain support from natural helpers or generic services. Does not require or seek mental health sevices.	

GAF SCORES

RAFLS LEVEL	MEAN
1	45.6
2	44.9
3	47.8
4	50.5
5	52
6	55.2

AXIS_V_GAF [1]

RAFLS	N	Subset 1	2	3	4	5
1	2559	45.6049				
2	4358	44.9312				
3	10747		47.8103			
4	4707			50.5037		
5	6473				51.9887	
6	7793					55.2297
Sig.		0.118	1	1	1	1

Means for groups in homogeneous subsets are displayed.
Based on Type III Sum of Squares
The error term is Mean Square(Error) = 128.119.

a. Uses Harmonic Mean Sample Size = 4964.266.

b. The group sizes are unequal. The harmonic mean of the group sizes is used. Type I error levels are not guaranteed.

c. Alpha = .05.

[1] Persons at functional level 1 (RAFLS 1) may be there for reasons related to risk rather than functioning. Therefore, their GAF scores may be higher than persons at functional level 2 (RAFLS 2).

PROBLEM AREAS BY RAFLS

RAFLS LEVEL	Criminal Justice %	Suicide threat,attempt,danger %	Drug Abuse %	Alcohol Abuse %	Thought Disorder %	Self-Care %	Role Performance %
1	43.1	10	38.1	22.4	47.4	17.3	42.6
2	6.9	13.3	11.6	12.5	54.1	29	47.2
3	7.3	11.8	14	12.9	50.5	22	41.4
4	11.9	12.9	16.4	14.3	32	18	43.8
5	3.8	12.1	10.2	10.9	30.4	10.7	38
6	3	9.4	7.1	9.3	31.6	8.7	26.9
% All	8.8	11.5	13.6	12.6	40.7	17.1	38.8

Attachment C

SERVICE DEFINITIONS

Based on HSRI prescriptions

July 28, 1999

I. COMMUNITY LIVING ARRANGEMENTS (RESIDENTIAL)

A. *Principles and Assumptions*

a. Community living arrangements are designed and developed to serve individuals with a range of needs, including persons with severe disabilities who need intensive, ongoing supports. Such supports may include training and assistance with bathing, cooking, cleaning, medication, health, and other self-care skills.

b. Community living arrangements can be provided and arranged in a variety of settings with a variety of different property relationships. They include site-specific residential models such a houses and clustered apartments which are owned or leased by service providers, as well as homes or apartment units owned or rented by individuals, with individualized supports available in these settings from clinical teams, case managers, or other service providers.

c. The preferred model for community living arrangements allows individuals to continue living at the same site, with the level of staff support modified over time to reflect their changing needs, rather than for them to move to a different site if they need more or less staff support. Ideally, individuals live in their own homes or share an apartment/home with others mutually selected by the individuals.

d. In all community living arrangements individuals are expected to contribute to the cost of housing through SSI or other available income. However, in all arrangements, and particularly supported housing, there will often be a housing or rental subsidy provided by ADHS or another governmental agency.

B. *Definitions*

1. Specialized Residential

These programs provide intensive support and/or skills training usually for no more than four residents with specialized service needs. These programs are especially designed to meet the needs of the following individuals, among others: medically involved residents, geriatric residents requiring intensive support, residents who experience severe behavioral symptoms, and residents with physical disabilities. All programs are designed to be individualized, integrated into the community and the most normal and least restrictive possible, consistent with the individual's needs.

2. Intensive Staff/Supervision

These programs focus on functional education to develop daily living skills such as bathing, cleaning, cooking, and other self-care skills. They are designed to provide a high level of staff involvement for those individuals requiring substantial skill training and support in a structured environment. These programs usually serve no more than four persons in a single location. All programs are designed to be individualized, integrated into the community and the most normal and least restrictive possible, consistent with the individual's needs.

3. Moderate Staff/Supervision

These programs are designed for individuals who require structure or verbal support to accomplish daily living skills, but do not require one to one attention to accomplish those tasks. These programs also include persons with substance abuse issues. The goal is to engage individuals in developing their own internal structure and control to live in the community. These programs usually serve no more than four persons in a single location. All programs are designed to be individualized, integrated into the community and the most normal and least restrictive possible, consistent with the individual's needs.

4. Minimum Staff/Supervision

These programs serve individuals who are capable of handling non-crisis issues for a day or two until a scheduled staff visit. Staff visits include support and assistance, skills training, and consultation with individuals who are part of the resident's natural support network. These programs usually serve no more than four persons in a single location. All programs are designed to be individualized, integrated into the community and the most normal and least restrictive possible, consistent with the individual's needs.

5. Independent Living w/Housing Subsidy

A setting where an individual can live either alone, with a relative, or friends in a home or apartment without ongoing supervision from mental health staff. There must be a sufficient array of stable, affordable housing, with subsidies, to permit all individuals with serious mental illness to live safely and permanently in the community.

6. Independent Living w/o Housing Subsidy (see above description)

II. EMERGENCY SERVICES

7. Crisis Outreach

A continuously available mental health service that provides short-term mental health services to individuals during an emergency or crisis situation. This service is not site based, but is provided to individuals in their homes, in shelters, on the street, or wherever the need arises.

8. Crisis Emergency Walk-In

This service provides immediate, short-term mental health services to individuals who are experiencing an emergency or crisis situation.

9. Crisis Residential

These programs provide 24 hour supports for individuals who are in crisis. Crisis programs should be in a non-hospital setting which are integrated into the community, and consistent with client needs, as well as the program's purposes, including providing a stable and safe setting. The goal of this service is to assist individuals in crisis in the least restrictive environments while trying to maintain the person's linkages with his/her larger community support system. Services provided include continuous and close supervision, medical, nursing and psychiatric attention (including medical stabilization) support, relief from stress, and referral to community based services.

10. Respite Care

These programs provide short term, twenty-four hour supports for individuals who need to leave their primary residence for a limited period of time or who need additional supports in their own residence (in-home) for a limited period of time. Distinct respite settings must be home like and integrated into the community.

III. INPATIENT HOSPITAL

11. Inpatient Specialty/State (ASH)

The provision of inpatient care within a unit designed to serve seriously mentally ill patients who are expected to be in the hospital beyond the acute phase of their illness but for whom discharge is a short-range goal. Primary services are oriented towards developing and implementing psychosocial rehabilitation programs and improving skills in activities of daily living (ADL) with the goal of maintaining the highest level of functioning in the community.

12. Inpatient General (Community Hospitals)

The provision of inpatient care within a unit designed to serve seriously mentally ill patients who have just been admitted or are experiencing an acute phase of their illness in the course of an extended hospitalization. Primary services are oriented toward developing a differential diagnosis, amending treatment plans to more fully respond to the acute needs of the stabilization of the patient's psychiatric condition and aggressive intervention.

13. Inpatient – Forensic

The provision of inpatient care within a unit designed to serve patients who are committed by a court to evaluate competency to stand trial, assess criminal responsibility, or provide recommendations for treatment. Services include clinical assessment, forensic evaluation, and short- or long-term treatment as appropriate based on the nature of the court commitment.

14. Inpatient – Detoxification

Treatment in which a person is monitored while withdrawing from a substance, as part of being treated for a substance abuse disorder.

IV. TREATMENT SERVICES

15. Evaluation/Diagnosis

An evaluation for the purposes of intake, treatment planning, eligibility determination or functional assessment by a qualified mental health professional. This includes psychiatric evaluation/mental status by a psychiatrist or other qualified mental health professional for diagnostic or disposition purposes, commitment evaluation, psychosocial evaluation and psychological evaluation with or without testing.

16. Court Ordered Evaluation (County)

An analysis of an individual's medical, psychological and social condition carried out by staff of a licensed mental health evaluation agency by order of the superior court of the county in which the persons resides, to determine whether the person is in need of court-ordered mental health treatment. These evaluations are the responsibility of county governments.

17. Individual Psychotherapy

Therapeutic interaction by a behavioral health practitioner to address the individual's therapeutic goals by providing emotional support, developing insight, producing cognitive/behavioral change, improving decision-making and/or reducing stress. May include education about management of a behavioral health disorder, including relapse prevention and recovery strategies.

18. Group Psychotherapy

Therapeutic interaction by a behavioral health practitioner to address the individual's therapeutic goals in a group of unrelated persons by providing emotional support, developing insight, producing cognitive/behavioral change, improving decision-making and/or reducing stress. May include education about management of a behavioral health disorder, including relapse prevention and recovery strategies.

19. Family Psychotherapy

Therapeutic interaction by a behavioral health practitioner with family members or significant others, with or without the presence of the individual to address the individual's therapeutic goals, by providing emotional support, developing insight, producing cognitive/behavioral change, improving decision-making and/or reducing stress. May include education about management of a behavioral health disorder, including relapse prevention and recovery strategies. May be provided to multiple families.

20. Therapeutic Supervision

a) Therapeutic supervision

Therapeutic supervision and direction to prevent placement in a more restrictive setting, which includes assistance with activities of daily living and household services incidental to, and consistent with, the behavioral health needs of the individual.

b) Personal Care

Personal care services include a range of assistance which enable persons with serious mental illness to accomplish tasks they would normally do for themselves if they did not have a disability. Assistance may be in the form of hands-on assistance, such as actually performing a personal care task for a person, or cueing so that the person performs the task by him/herself. The tasks which personal care can assist with include, but are not limited to: eating, bathing, dressing, toileting, transferring, maintaining continence, personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management.

21. Outpatient Detoxification

An outpatient, non-residential program to systematically reduce dependence on alcohol and other drugs. May require daily contact for administration of medications and monitoring of withdrawal symptoms.

22. Substance Abuse Counseling

A structured outpatient treatment program consisting of a minimum of three hours of group substance abuse treatment three times a week.

23. Methadone Maintenance Clinic

Social/medical services provided in conjunction with methadone treatment. Methadone is used as an oral substitute for opiates during the rehabilitative phase of treatment. This is not the pharmacy claim for Methadone. Only outpatient services will be included.

V. REHABILITATION

A. *Vocational Principles and Assumptions*

a. Vocational services should be provided through several supported employment program models. These models, as defined below, include individual supported employment, intensive supported employment, extended supported employment, and group supported employment.

b. Although vocational services may be delivered through the group employment model, this model is not preferred and has not been used in the projection of needs or costs.

c. Although new vocational services and resources, as projected in this plan, will be delivered through these four models, other models used for existing services would not be expanded through this plan but may be continued with current funding sources.

d. All supported employment services should be individualized, adequate, integrated, and provided as long as necessary to ensure that the person continues to need them to retain their jobs.

e. Supported employment services should be designed and delivered to ensure that individuals are paid at least the minimum wage and work at least fifteen hours a week.

f. Community employment means work that is performed on a full-time or part-time basis in an integrated setting for which an individual is compensated at, or above, the federal minimum wage.

g. Integrated settings mean training or work which is not a self-contained work environment.

B. *Definitions*

24. Psychosocial Rehabilitation

a) Social Rehabilitation

Services or activities providing opportunities to develop functional skills, foster social role integration and make informed life and work choices in a supportive and flexible atmosphere, including such activities as work exploration, volunteering, trying out work, or any activity that may lead toward more traditional vocational rehabilitation services or employment. Includes the development of individualized supports in individuals which are designed to facilitate more meaningful participation by individuals in their communities in order to increase their involvement in generic community activities such as clubs, churches, community organizations, etc.

b) Skills Training

An array of approaches to assist individuals to acquire basic vocational and educational skills in the program of their choice in the community.

c) Community Support Clubhouse/Transitional Employment Program

A community support clubhouse provides support services through a comprehensive self-help clubhouse. Staff and members work as teams to perform the tasks necessary for the operation of the clubhouse. Transitional Employment Programs are designed to provide employment experiences that prepare individuals for competitive employment.

25. Consumer Operated Services

A consumer operated drop-in center/social club provides an informal and welcoming environment for individuals to come for social/recreational activities and peer advocacy.

26. Vocational Assessment/Counseling

The comprehensive assessment of an individual's vocational skills, attitudes, behaviors and interests through a variety of formal and informal methods.

27. Supported Employment

Secures or works with employers to create a real job in the community paying a competitive wage with staff support on the job, including intensive on-the-job skill training, job related social skills training, frequent follow-up services in order to reinforce and stabilize the job placement, facilitation of natural supports at the work site and other discrete services as necessary. Supports should be adequate to allow an individual to work a minimum of fifteen hours per week and earn at least a minimum wage.

a) Individual Supported Employment

These programs secure or work with employers to create a real job in the community paying a competitive wage with staff support on the job, including intensive on-the-job skill training, job related social skills training, frequent follow-up services in order to reinforce and stabilize the job placement, facilitation of natural supports at the work site and other discrete services as necessary. Supports should be adequate to allow an individual to work a minimum of fifteen hours per week and earn a minimum wage.

b) Extended Supported Employment

Extended Supported Employment provides long term, indefinite on-going support for an employed individual (including counseling, regular contacts with the individual and/or employer, job monitoring, finding a new job when necessary, maintaining established and on-going natural and peer supports) in order to assist individuals maintain employment in the community. Supports should be adequate to allow the individual to work a minimum of fifteen hours per week and earn minimum wage.

c) Intensive Supported Employment

These programs include all the services associated with Supported Employment. However, the supports and on-site supervision required by the consumer to obtain and maintain employment in the community are at a much more intensive level, up to at least daily on-site contact. Supports should be adequate to allow an individual to work a minimum of fifteen hours per week and earn a minimum wage.

d) Group Supported Employment

These programs secure or work with employers to create a real job in the community paying a competitive wage with staff support on the job, including intensive on-the-job skill training, job related social skills training, frequent follow-up services in order to reinforce and stabilize the job placement, facilitation of natural supports at the work site and other discrete services as necessary. Supports should be adequate to allow an individual to work a minimum of fifteen hours per week and earn minimum wage. Group Supported Employment utilizes group placement such as consumer-run businesses or enclaves.

28. Supported Education and Other Educational Services

a). Supported Education

These programs consist of higher education opportunities for persons with severe mental illness. It provides necessary supports such as study skills training and social skills training, etc. It may be an intensive college preparatory program designed specifically for persons with serious mental illness or a specialized vocation program. Services should be provided in the community, within the consumer's educational setting of choice, with the full range of educational facilities available to consumers.

b). Other Education

Assistance in locating or providing to people with severe mental illness a full range of educational services from basic literacy through GED (General Equivalency Diploma) and educational counseling for college, technical education, or other courses.

VI. COMMUNITY SUPPORTS

29. Assertive Community Treatment Teams (ACT)

An array of services that are provided by community-based, mobile mental health treatment teams to seriously mentally ill persons wherever they are found, seven days a week, 24-hours a-day. Team composition consists of a psychiatrist, case managers, nurses, team rehabilitation specialist, employment specialists, housing specialist, independent living skills specialist, and consumer case managers/counselors. In this model actual services, as well as person-centered learning and coordination of services, are provided at very low staff-to-client ratios that allow continuous contact with the individual. Average caseloads of case managers is 12, with additional specialists and representatives of other providers joining the team to meet specific needs of individuals.

30. Intensive Clinical Services

Refers to the interdisciplinary team of persons who are responsible for providing core treatment and support to a client and for locating, accessing and monitoring the provision of other behavioral health specialists, other involved service providers and other professionals, such as a psychologist, social worker, consumer case management aide, rehabilitation and housing specialists, as needed, based on the client's needs. Primary functions include: psychiatric services, assessment/evaluations, planning/coordination; linkage; contact with the consumer, advocacy; monitoring; resource development and outcome measurement. Typically in this model caseload averages are no larger than twelve for intensive and not to exceed thirty-five persons of lesser need.

31. Medication Management

Services provided by a physician to evaluate, prescribe, and monitor medications for the treatment of psychiatric disorders. Includes medication review and administration services provided by an RN under the supervision/order of a physician. Includes visits for the purpose of prescribing medication as well as for medication refills or dosage regulation. Medication service does not include methadone maintenance, etc. or detoxification.

32. Protection and Advocacy

Assisting consumers with legal matters related to their mental health service needs and rights.

33. Client Transportation

Transportation services to assist consumers in getting to services, employment, and other activities.

34. Family Psychoeducation

Consultation and education to families concerning the nature, consequences, and treatment of severe and chronic mental illness. This service is usually provided to groups of more than one family at a time. Note: this is not the same as family treatment. Units of service are measured in face-to-face hours.

35. Friend Advocacy

A program that recruits, trains, and supports volunteers who provide advocacy, friendship, and support to individuals with serious mental illness.

Attachment D

			AVG % PER MONTH						AVG AMOUNT PER MONTH (PER CLIENT RECEIVING THE SERVICE)					
	Units	UNIT COST	1	2	3	4	5	6	1	2	3	4	5	6
RESIDENTIAL														
1 Intensive Staff/ Supervision	days	$250.00	10	5	10				30.42	30.42	30.42			
2 Moderate Staff/ Supervision	days	$200.00	10	2.5	15	15	10		30.42	30.42	30.42	30.42	30.42	
3 Minimum Staff/ Supervision	days	$80.00			20	25					30.42	30.42		
4 Indep. Living w/ Subsidized Housing	days	$11.51	35	50	25	30	45	45	30.42	30.42	30.42	30.42	30.42	30.42
5 Indep. Living w/o Subsidized Housing	days		25	40	23	25	45	55	30.42	30.42	30.42	30.42	30.42	30.42
6 Specialized Residential	days	$275.00	20	2.5	7	5			30.42	30.42	30.42	30.42		
SUBTOTAL			100	100	100	100	100	100						
EMERGENCY SERVICES														
7 Crisis Outreach	hours	$115.00	25	20	10	15	5	1	4	4	4	4	2	2
8 Crisis Emergency Walk-in	hours	$185.00	10	15	5	10	2	0	15	5	3	3	3	3
9 Crisis Residential	days	$285.00	20	15	5	10	5		5	5	5	3	3	
10 Respite Care	days	$132.00		5	10	10	2.5			5	5	3	3	
SUBTOTAL														
HOSPITAL & CRISIS														
11 Inpatient - Specialty/State	days	$285.00	30	5	1	1			15	10	10	10		
12 Inpatient - General	days	$440.00	15	15	1	1			7	7	5	5		
13 Inpatient - Forensic	days	$285.00	0	0					5	5				
14 Inpatient - Detox	days	$150.00	10	2	1	1	1		5	5	5	5	5	
SUBTOTAL														
TREATMENT														
15 Evaluation (Diagnosis)	hours	$110.00		2	2	2	2	2		2	2	3	2	2
16 Court Ordered Evaluation	hours	$110.00		1	1	1	1			4	2	2	2	
17 Individual Psycho-Therapy	hours	$85.00	5	5	5	10	20	20	3	3	3	3	3	2
18 Group Psycho-Therapy	hours	$30.00		5	15	10	10	5		4	4	4	4	4
19 Family Psycho-Therapy	hours	$80.00		5	5	5	5	5		4	3	3	3	3
20 Therapeutic Supervision	hours	$25.00	25	15	15	15			8	8	12	12		
21 Outpatient Detox	hours	$75.00		5	2	1	1			20	20	20	20	
22 Substance Abuse Counseling	hours	$75.00	25	20	15	20	20	20	6	5	5	5	5	5
23 Methadone Maintenance Clinic	week	$75.00					0.5						4	
SUBTOTAL														
REHABILITATION														
24 Psychosocial Rehabilitation	hours	$11.00	10	15	25	25	25	5	40	40	80	20	20	20
25 Consumer Operated Services	hours	$5.00	30	40	35	40	35	20	40	40	50	20	20	5
26 Vocational Assessment	hours	$80.00		0	3	1	1	1		4	5	5	5	5
27 Supported Employment	hours	$80.00		10	40	35	50			10	40	25	10	
28 Support Ed. & Other Ed Services	hours	$30.00		0	0	5	10	0		0	0	12	12	0
SUBTOTAL														
SUPPORT														
29 ACT	hours	$123.00	25	20	10	15	5		15	10	4	5	2	
30 Intensive Clinical Services	hours	$80.00	75	80	80	85	55		8	8	4	5	1	
31 Medication Management	hours	$64.00					40	100					1	1
32 Protection & Advocacy	hours	$22.50	25	10	5	5	4		5	3	2	2	2	
33 Client Transportation	hours	$10.00	25	15	10	10	5		10	10	10	10	1	
34 Family Psycho- Education	hours	$80.00	20	20	10	10	20		4	4	4	4	3	
35 Friend Advocacy		$83.00	0	0	20	35	10	0	0	0	1	1	1	0
SUBTOTAL														
TOTAL														

UTILIZATION PER MONTH

(avg % per mh. X avg. amt. Per mh.)

	1	2	3	4	5	6
RESIDENTIAL						
Intensive Staff Supervision	3.042	1.521	3.042	0	0	0
Moderate Staff Supervision	3.042	0.7605	4.563	4.563	3.042	0
Minimum Staff Supervision	0	0	6.084	7.605	0	0
Indep. Living w/ Subsidized Housing	10.647	15.21	7.605	9.126	13.689	13.689
Indep. Living w/o Subsidized Housing	7.605	12.168	6.9966	7.605	13.689	16.731
Specialized Residential	6.084	0.7605	2.1294	1.521	0	0
SUBTOTAL	30.42	30.42	30.42	30.42	30.42	30.42
EMERGENCY SERVICES						
Crisis Outreach	1	0.8	0.4	0.6	0.1	0.02
Crisis Emergency Walk-in	1.5	0.75	0.15	0.3	0.06	0
Crisis Residential	1	0.75	0.25	0.3	0.15	0
Respite Care	0	0.25	0.5	0.3	0.075	0
SUBTOTAL						
HOSPITAL & CRISIS						
Inpatient - Specialty/State	4.5	0.5	0.1	.0.1	0	0
Inpatient - General	1.05	1.05	0.05	0.05	0	0
Inpatient - Forensic	0	0	0	0	0	0
Inpatient - Detox	0.5	0.1	0.05	0.05	0.05	0
SUBTOTAL						
TREATMENT						
Evaluation (Diagnosis)	0	0.04	0.04	0.06	0.04	0.04
Court Ordered Evaluation	0	0.04	0.02	0.02	0.02	0
Individual Psycho-Therapy	0.15	0.15	0.15	0.3	0.6	0.4
Group Psycho-Therapy	0	0.2	0.6	0.4	0.4	0.2
Family Psycho-Therapy	0	0.2	0.15	0.15	0.15	0.15
Therapeutic Supervision	2	1.2	1.8	1.8	0	0
Outpatient Detox	0	1	0.4	0.2	0.2	0
Substance Abuse Counseling	1.5	1	0.75	1	1	1
Methadone Maintenance Clinic	0	0	0	0	0.02	0
SUBTOTAL						
REHABILITATION						
Psychosocial Rehabilitation	4	6	20	5	5	1
Consumer Operated Services	12	14	17.5	8	7	1
Vocational Assessment	0	0	0.15	0.05	0.05	0.05
Supported Employment	0	1	16	13.75	5	0
Supported Ed. & Othr Ed Services	0	0	0	0.86	1.2	0
SUBTOTAL	16	23	54	28	18	2
SUPPORT						
ACT	3.75	2	0.4	0.75	0.1	0
Intensive Clinical Services	6	6.4	3.6	4.25	0.55	0
Medication Management	0	0	0	0	0.4	1
Protection & Advocacy	2	0.3	0.16	0.16	0.08	0
Client Transportation	2.5	1.5	1	1	0.05	0
Family Psycho- Education	0.8	0.8	0.4	0.4	0.3	0
Friend Advocacy	0	0	0.2	0.35	0.1	0
SUBTOTAL	15	11	6	7	1	1
TOTAL						

SERVICE PACKAGE OPTIONS (SPO) COST PER MONTH

(Utilization x unit cost)

	1	2	3	4	5	6
RESIDENTIAL						
Intensive Staff Supervision	761	380	761	0	0	0
Moderate Staff Supervision	608	152	913	913	608	0
Minimum Staff Supervision	0	0	548	684	0	0
Indep. Living w/ Subsidized Housing	123	175	88	105	158	158
Indep. Living w/o Subsidized Housing	0	0	0	0	0	0
Specialized Residential	1,673	209	586	418	0	0
SUBTOTAL	2,165	917	2,894	2,120	766	158
EMERGENCY SERVICES						
Crisis Outreach	115	92	46	69	12	2
Crisis Emergency Walk-in	249	125	25	50	10	0
Crisis Residential	285	214	71	86	43	0
Respite Care	0	33	86	40	10	0
SUBTOTAL	649	463	228	244	74	2
HOSPITAL & CRISIS						
Inpatient - Specialty/State	1,280	143	29	29	0	0
Inpatient - General	462	462	22	22	0	0
Inpatient - Forensic	0	0	0	0	0	0
Inpatient - Detox	75	15	8	8	8	0
SUBTOTAL	1,828	620	58	58	8	0
TREATMENT						
Evaluation (Diagnosis)	0	4	4	7	4	4
Court Ordered Evaluation	0	4	2	2	2	0
Individual Psycho-Therapy	13	13	13	26	51	34
Group Psycho-Therapy	0	4	12	8	8	4
Family Psycho-Therapy	0	16	12	12	12	12
Therapeutic Supervision	50	30	45	45	0	0
Outpatient Detox	0	75	30	15	15	0
Substance Abuse Counseling	113	75	56	75	75	75
Methadone Maintenance Clinic	0	0	0	0	2	0
SUBTOTAL	175	222	175	[illegible]	[illegible]	129
REHABILITATION						
Psychosocial Rehabilitation	44	66	220	55	55	11
Consumer Operated Services	80	80	88	40	35	5
Vocational Assessment	0	0	9	3	3	3
Supported Employment	0	80	880	825	-300	0
Supported Ed. & Othr Ed Services	0	0	0	29	36	0
SUBTOTAL	184	286	1,277	952	429	19
SUPPORT						
ACT	461	246	48	82	12	0
Intensive Clinical Services	540	576	324	383	50	0
Medication Management	0	0	0	0	26	64
Protection & Advocacy	45	7	4	4	2	0
Client Transportation	25	15	10	10	1	0
Family Psycho- Education	48	48	24	24	16	0
Friend Advocacy	0	0	17	29	8	0
SUBTOTAL	1,119	882	427	541	116	64
TOTAL	7,032	3,310	5,038	4,185	1,582	372

SNAPSHOT PERCENTAGES FOR STRATEGY:

% in each level:	0.07	0.119	0.293	0.128	0.177	0.213	1
Totals:	$70,577,383	$56,067,[illegible]	$212,581,377	$75,[illegible]	$58,[illegible]	$11,417,971	$467,207,[illegible]
cost per client per level	$482	$385	$1,476	$525	$276	$79	$3,244
							total per client/mo.

Avg. Cost/Client/Year	$38,[illegible]
Total Cost/Year	$467,207,[illegible]

Clients	12000
Mo.	12

TOTAL CONSUMERS

	1	2	3	4	5	6	Total
RESIDENTIAL							
1 Intensive Staff Supervision	84	71.4	351.8	0	0	0	507
2 Moderate Staff Supervision	84	35.7	527.4	230.4	212.4	0	1089.9
3 Minimum Staff Supervision	0	0	703.2	384	0	0	1087.2
4 Indep. Living w/ Subsidized Housing	294	714	879	460.8	855.8	1150	4453.6
5 Indep. Living w/o Subsidized Housing	210	571.2	808.68	384	855.8	1406	4335.48
6 Specialized Residential	168	35.7	246.12	76.8	0	0	526.62
SUBTOTAL	840	1428	3516	1536	2124	2556	12000
EMERGENCY SERVICES							
7 Crisis Outreach	210	285.6	351.6	230.4	106.2	25.56	1209.36
8 Crisis Emergency Walk-in	84	214.2	175.8	153.6	42.48	0	670.08
9 Crisis Residential	168	214.2	175.8	153.6	106.2	0	817.8
10 Respite Care	0	71.4	351.6	153.6	53.1	0	629.7
SUBTOTAL	462	785.4	1054.8	691.2	308	25.56	3326.94
HOSPITAL & CRISIS							
11 Inpatient - Specialty/State	252	71.4	35.16	15.36	0	0	373.92
12 Inpatient - General	126	214.2	35.16	15.36	0	0	390.72
13 Inpatient - Forensic	0	0	0	0	0	0	0
14 Inpatient - Detox	84	28.56	35.16	15.36	21.24	0	184.32
SUBTOTAL	462	314.2	105.48	46.08	21.24	0	948.96
TREATMENT							
15 Evaluation (Diagnosis)	0	28.56	70.32	30.72	42.48	51.12	223.2
16 Court Ordered Evaluation	0	14.28	35.16	15.36	21.24	0	86.04
17 Individual Psycho-Therapy	42	71.4	175.8	153.6	424.8	511.2	1378.8
18 Group Psycho-Therapy	0	71.4	527.4	153.6	212.4	127.8	1092.6
19 Family Psycho-Therapy	0	71.4	175.8	76.8	106.2	127.8	558
20 Therapeutic Supervision	210	214.2	527.4	230.4	0	0	1182
21 Outpatient Detox	0	71.4	70.32	15.36	21.24	0	178.32
22 Substance Abuse Counseling	210	285.6	527.4	307.2	424.8	511.2	2266.2
23 Methadone Maintenance Clinic	0	0	0	0	10.62	0	10.62
SUBTOTAL	462	828.2	2109.6	983.04	1264	1329	6875.78
REHABILITATION							
24 Psychosocial Rehabilitation	84	214.2	879	384	531	127.8	2220
25 Consumer Operated Services	252	571.2	1230.6	614.4	743.4	511.2	3922.8
26 Vocational Assessment	0	0	105.48	15.36	21.24	25.56	167.64
27 Supported Employment	0	142.8	1406.4	844.8	1062	0	3456
28 Support Ed. & Othr Ed Services	0	0	0	122.88	212.4	0	335.28
SUBTOTAL	336	928.2	3621.5	1981.4	2570	664.6	10101.72
SUPPORT							
29 ACT	210	285.6	351.6	230.4	106.2	0	1183.8
30 Intensive Clinical Services	630	1142	3164.4	1305.6	1168	0	7410.6
31 Medication Management	0	0	0	0	848.6	2556	3405.6
32 Protection & Advocacy	210	142.8	281.28	122.88	84.96	0	841.92
33 Client Transportation	210	214.2	351.6	153.6	106.2	0	1035.6
34 Family Psycho- Education	168	285.6	351.6	153.6	212.4	0	1171.2
35 Friend Advocacy	0	0	703.2	537.6	212.4	0	1453.2
SUBTOTAL	1428	2071	5203.7	2503.7	2740	2556	16501.92
TOTAL							

TOTAL MONTHLY COSTS

	1	2	3	4	5	6
RESIDENTIAL						
1 Intensive Staff Supervision	638820	542,997	2,673,918	0	0	0
2 Moderate Staff Supervision	511,056	217,199	3,208,702	1,401,754	1,292,242	0
3 Minimum Staff Supervision	0	0	1,925,221	1,051,315	0	0
4 Indep. Living w/ Subsidized Housing	102,939	249,996	307,768	161,342	334,658	402,724
5 Indep. Living w/o Subsidized Housing	0	0	0	0	0	0
6 Specialized Residential	1,405,404	298,648	2,058,917	642,470	0	0
SUBTOTAL	2,658,219	1,308,840	10,174,525	3,256,881	1,626,900	402,724
EMERGENCY SERVICES						
7 Crisis Outreach	96,600	131,376	161,736	105,984	24,426	5,879
8 Crisis Emergency Walk-in	209,160	177,786	87,548	76,493	21,155	0
9 Crisis Residential	239,400	305,235	250,515	131,328	90,801	0
10 Respite Care	0	47,124	232,056	60,826	21,028	0
SUBTOTAL	545,160	661,521	731,855	374,630	157,410	5,879
HOSPITAL & CRISIS						
11 Inpatient - Specialty/State	1,077,300	203,490	100,206	43,776	0	0
12 Inpatient - General	388,080	659,736	77,352	33,792	0	0
13 Inpatient - Forensic	0	0	0	0	0	0
14 Inpatient - Detox	63,000	21,420	26,370	11,520	15,930	0
SUBTOTAL	1,528,380	884,646	203,928	89,088	15,930	0
TREATMENT						
15 Evaluation (Diagnosis)	0	6,283	15,470	10,138	8,346	11,246
16 Court Ordered Evaluation	0	6,283	7,735	3,379	4,673	0
17 Individual Psycho-Therapy	10,710	18,207	44,829	39,168	108,324	86,904
18 Group Psycho-Therapy	0	5,712	42,192	12,288	16,992	10,224
19 Family Psycho-Therapy	0	22,848	42,192	18,432	25,488	30,672
20 Therapeutic Supervision	42,000	42,840	158,220	88,120	0	0
21 Outpatient Detox	0	107,100	105,480	23,040	31,860	0
Substance Abuse Counseling	94,500	107,100	197,775	115,200	158,300	191,700
Methadone Maintenance Clinic	0	0	0	0	3,186	0
SUBTOTAL	147,210	316,373	613,894	290,765	358,168	330,746
REHABILITATION						
24 Psychosocial Rehabilitation	35,960	94,248	773,520	84,480	116,820	28,116
25 Consumer Operated Services	50,400	114,240	307,950	61,440	74,340	12,780
26 Vocational Assessment	0	0	31,644	4,608	6,372	7,668
27 Sponsored Employment	0	85,680	3,375,360	1,267,200	637,200	0
28 Support Ed. & Othr Ed Services	0	0	0	44,237	76,464	0
SUBTOTAL	87,360	294,168	4,488,174	1,461,965	911,196	48,564
SUPPORT						
29 ACT	387,450	351,288	172,987	141,696	26,125	0
30 Intensive Clinical Services	453,800	822,528	1,139,184	587,520	105,138	0
31 Medication Management	0	0	0	0	54,374	163,584
32 Protection & Advocacy	37,800	9,639	12,858	5,530	3,823	0
33 Client Transportation	21,000	21,420	35,160	15,360	1,062	0
34 Family Psycho- Education	40,320	68,544	84,384	36,864	38,232	0
35 Friend Advocacy	0	0	58,366	44,621	17,629	0
SUBTOTAL	940,170	1,273,419	1,502,738	831,590	246,384	163,584
TOTAL						

TOTAL ANNUAL COSTS

	1	2	3	4	5	6	
RESIDENTIAL							
1 Intensive Staff/ Supervision	7,665,840	6,515,964	32,087,016	0	0	0	46,268,820
2 Moderate Staff/ Supervision	6,132,672	2,606,386	38,504,419	16,821,043	15,506,899	0	79,571,419
3 Minimum Staff/ Supervision	0	0	23,102,652	12,615,782	0	0	35,718,434
4 Indep. Living w/ Subsidized Housing	1,235,273	2,999,950	3,893,216	1,936,102	4,015,899	4,832,692	18,713,132
5 Indep. Living w/o Subsidized housing	0	0	0	0	0	0	0
6 Specialized Residential	16,864,848	3,583,780	24,707,002	7,709,645	0	0	52,865,275
SUBTOTAL	31,898,633	15,706,080	122,094,305	39,082,572	19,522,798	4,832,692	233,137,081
EMERGENCY SERVICES							
7 Crisis Outreach	1,159,200	1,576,512	1,940,832	1,271,808	293,112	70,546	6,312,010
8 Crisis Emergency Walk-in	2,509,920	2,133,432	1,050,581	917,914	253,860	0	6,865,707
9 Crisis Residential	2,872,800	3,862,820	3,006,180	1,575,936	1,089,612	0	12,207,348
10 Respite Care	0	565,488	2,784,672	729,907	252,331	0	4,332,398
SUBTOTAL	6,541,920	7,938,252	8,782,265	4,495,565	1,888,916	70,546	29,717,463
HOSPITAL & CRISIS							
11 Inpatient - Specialty/State	12,927,600	2,441,880	1,202,472	525,312	0	0	17,097,264
12 Inpatient - General	4,656,960	7,916,832	928,224	405,504	0	0	13,907,520
13 Inpatient - Forensic	0	0	0	0	0	0	0
14 Inpatient - Detox	756,000	257,040	316,440	138,240	191,160	0	1,658,880
SUBTOTAL	18,340,560	10,615,752	2,447,136	1,069,056	191,160	0	32,663,664
TREATMENT							
15 Evaluation (Diagnosis)	0	75,398	185,645	121,651	112,147	134,957	629,798
16 Court Ordered Evaluation	0	75,398	82,822	40,550	56,074	0	254,845
17 Individual Psycho-Therapy	128,520	218,484	537,948	470,016	1,298,888	1,042,848	3,697,704
18 Group Psycho-Therapy	0	68,544	506,304	147,456	203,904	122,688	1,048,896
19 Family Psycho-Therapy	0	274,176	506,304	221,184	305,856	368,064	1,675,584
20 Therapeutic Supervision	504,000	514,080	1,898,640	829,440	0	0	3,746,160
21 Outpatient Detox	0	1,285,200	1,285,788	276,480	382,320	0	3,209,788
22 Substance Abuse Counseling	1,134,000	1,285,200	2,373,309	1,382,400	1,911,600	2,300,400	10,386,909
23 Methadone Maintenance Clinic	0	0	0	0	38,232	0	38,232
SUBTOTAL	1,786,520	3,786,481	7,386,723	3,489,178	4,310,021	3,968,957	24,697,879
REHABILITATION							
24 Psychosocial Rehabilitation	443,520	1,130,976	9,282,240	1,013,760	1,401,840	337,392	13,609,728
25 Consumer Operated Services	604,800	1,370,880	3,891,600	737,280	892,080	153,360	7,450,200
26 Vocational Assessment	0	0	379,728	55,296	76,464	92,016	603,504
27 Supported Employment	0	1,028,160	40,504,320	15,206,400	7,646,400	0	64,385,280
28 Support Ed. & Othr Ed Services	0	0	0	530,842	917,568	0	1,448,410
SUBTOTAL	1,048,320	3,530,016	53,858,088	17,543,578	10,934,352	582,768	87,497,122
SUPPORT							
29 ACT	4,649,400	4,215,456	2,075,845	1,700,352	313,502	0	12,954,557
30 Intensive Clinical Services	5,443,200	9,870,336	13,670,208	7,050,240	1,261,656	0	37,295,640
31 Medication Management	0	0	0	0	652,480	1,963,008	2,615,501
32 Protection & Advocacy	453,600	115,668	151,891	86,355	45,878	0	853,393
33 Client Transportation	252,000	257,040	421,920	184,320	12,744	0	1,128,024
34 Family Psycho- Education	483,840	822,528	1,912,608	442,368	458,784	0	3,220,128
35 Friend Advocacy	0	0	700,387	535,450	211,550	0	1,447,387
SUBTOTAL	11,282,040	15,281,028	18,932,861	9,979,085	2,956,808	1,963,008	59,494,630
TOTAL	70,877,993	56,857,808	212,581,377	75,658,033	39,803,855	11,417,971	467,207,838

Attachment E

Arnold v. Sarn Exit Stipulation Worksheet

The 1996 *Exit Stipulation on Disengagement* establishes the compliance requirements necessary to meet the remaining obligations of *Arnold v. Sarn*. These obligations do not require full funding of all services for all class members. Full funding has therefore been reduced under an agreed upon formula.

This formula has been defined as follows:

1. 100% of funding for all "High Priority" persons;[1]
2. 80% of funding for all "Other Priority" persons;[2] and
3. 80% of funding for 85% of "Non Priority" persons.[3]

The chart below represents the estimated cost of meeting these obligations, including medication and administration, based on the above weighting:

2)	Dynamic model expenditure/cost estimate		3) Weighting of dir.costs accord. to parties		Weight	EXIT STIP VERSION		100% VERSION
High Priority	40065849		High Priority	$40,065,849	1	$40,065,849	1	$40,065,849
Other Priority	38486174		Other Priority	$38,486,174	0.8	$30,788,939	1	$38,486,174
Non Priority	291462775		Non Priority	$291,462,775	0.68	$198,194,687	1	$291,462,775
	370015798		Total Service	$370,015,798		$269,050,475		$370,015,798
			4) Weighting of medication costs according to parties					
	Total Meds	33635375	HP Meds	$3,642,178.25	1	$3,642,178	1	$3,642,178
			OP meds	$3,498,480.88	0.8	$2,798,783	1	$3,498,491
			NP meds	$26,494,705.87	0.68	$18,016,400	1	$26,494,705
			Total Meds	$33,635,375		$24,457,371		$33,635,375
			5) Addition of admin at 8% to direct service + medications according to parties					
			Total Service +meds			$293,507,846		$403,651,173
			Admin %			0.08		0.08
			ADM			$23,480,628		$32,292,094
			Total Serv. + meds + adm [4]			$316,988,474		$435,943,267
			Total per Client @ 12000+(2465712*11)	14,258		$22,233		$30,576

[1] "High Priority" means persons who are in supervisory care homes or who have been in the Arizona State Hospital.

[2] "Other Priority" means persons who are frequent crisis or inpatient users, need 24 hour residential services or who are in jail with a major biological disorder (such as schizophrenia and bipolar disorder).

[3] "Non Priority" means all other class members in Maricopa County.

[4] The actual amount of new money needed will be less than these totals, depending on use of existing funding and resources.

Transition Rates Estimated for Arizona (1999) Service Packages,
Base data: Transition Rates from Arizona (1998) and California (Hargraves, 1986)

	death	dis	FL1	FL2	FL3	FL4	FL5	FL6	FL7
FL1	0.005	0.037	0.624	0.118	0.050	0.154	0.007	0.005	0.000
FL2	0.004	0.037	0.059	0.624	0.129	0.037	0.068	0.002	0.000
FL3	0.003	0.037	0.006	0.031	0.716	0.184	0.022	0.001	0.000
FL4	0.003	0.037	0.014	0.019	0.059	0.734	0.111	0.013	0.000
FL5	0.002	0.037	0.004	0.007	0.015	0.073	0.747	0.103	0.013
FL6	0.001	0.037	0.000	0.008	0.000	0.008	0.050	0.879	0.017

Persons With Severe Mental Illness in Jails and Prisons: A Review

Appendix I to Mental Health Task Force Report, November 30, 1999

H. Richard Lamb, M.D.
Linda E. Weinberger, Ph.D.

Objective: The presence of severely mentally ill persons in jails and prisons is an urgent problem. This review examines this problem and makes recommendations for preventing and alleviating it. *Methods:* MEDLINE, *Psychological Abstracts*, and the *Index to Legal Periodicals and Books* were searched from 1970, and all pertinent references were obtained. *Results and Conclusions:* Clinical studies suggest that 6 to 15 percent of persons in city and county jails and 10 to 15 percent of persons in state prisons have severe mental illness. Offenders with severe mental illness generally have acute and chronic mental illness and poor functioning. A large proportion are homeless. It appears that a greater proportion of mentally ill persons are arrested compared with the general population. Factors cited as causes of mentally ill persons' being placed in the criminal justice system are deinstitutionalization, more rigid criteria for civil commitment, lack of adequate community support for persons with mental illness, mentally ill offenders' difficulty gaining access to community treatment, and the attitudes of police officers and society. Recommendations include mental health consultation to police in the field; formal training of police officers; careful screening of incoming jail detainees; diversion to the mental health system of mentally ill persons who have committed minor offenses; assertive case management and various social control interventions, such as outpatient commitment, court-ordered treatment, psychiatric conservatorship, and 24-hour structured care; involvement of and support for families; and provision of appropriate mental health treatment. (*Psychiatric Services* 49:483–492, 1998)

Mental health professionals have become increasingly concerned about the number of persons with mental illness in jails and prisons. This issue is a relatively recent one. Reports of large numbers of mentally ill persons in American jails and prisons began appearing in the 1970s (1–3). This phenomenon had not been reported since the 19th century (4).

To better understand this problem, a literature review was conducted. Two of the primary questions addressed were whether large numbers of persons with severe mental illness who commit legal transgressions are being taken to jails and sent to prisons instead of to hospitals or other psychiatric treatment facilities, and whether the number has increased since deinstitutionalization.

The review also examined other aspects of this issue, including the characteristics of mentally ill offenders, factors cited as causes of mentally ill persons' being placed in the criminal justice system, the relationship between mental illness and violence, access to treatment for this population, the role of the police, and society's attitudes toward mentally ill offenders. Finally, recommendations are made about how inappropriate placement of this population in the criminal justice system can be prevented and how to treat mentally ill offenders both in the system and after they are released into the community.

Methods

MEDLINE, *Psychological Abstracts*, and the *Index to Legal Periodicals and Books* were searched from 1970, and all relevant references were obtained.

Results and discussion

Incarceration versus hospitalization

Many factors come into play in determining why a person with mental illness is arrested rather than taken to a hospital. Generally, persons who are thought to have committed a felony are arrested and brought to jail regardless of their mental condition. The criminal justice system, charged by society with the responsibility for removing from the community persons accused of committing serious crimes, sees no alternative but to first place the person in custody in a secure setting and then arrange for psychiatric treatment if necessary (5). If the person is thought to have committed a serious crime, the police and the criminal justice system generally do not want to leave this person in a psychiatric hospital where security may be lax, the offense may be seen by staff as secondary to the patient's illness, and the person may be released to the community in a relatively short time.

Dr. Lamb is professor of psychiatry and director of the division of mental health policy and law of the department of psychiatry at the University of Southern California School of Medicine, 1937 Hospital Place, Los Angeles, California 90033. Dr. Weinberger is associate professor of clinical psychiatry and chief psychologist at the Institute of Psychiatry, Law, and Behavioral Sciences of the University of Southern California School of Medicine.

For persons charged with misdemeanors, the situation becomes more complex. In 1972 Abramson (6) was the first to coin the term "criminalization of the mentally ill". He observed that persons with mental disorders who engaged in minor crimes were increasingly subject to arrest and prosecution in a county jail system. Subsequently, many authors applied the concept of criminalization to persons with mental disorders who were arrested for serious crimes.

The distinction between arrest and incarceration of mentally ill persons who have committed minor offenses and those who have committed serious offenses is an important one. As Steury (7) notes, no consensus exists on the definition of criminalization of persons with mental disorders. Some researchers define criminalization at the point of arrest (8–11) and others require prosecution (12–15), while others use incarceration in jails and prisons (16,17).

In our opinion, the term criminalization should be used primarily in connection with mentally ill persons who are arrested, with or without jail detention, and prosecuted for minor offenses instead of being placed in the mental health system. As noted, it is clear that persons who have committed serious offenses, no matter how mentally ill, would normally be processed in the criminal justice system (13,18,19). However, it should be acknowledged that many mentally ill persons who commit serious crimes and enter the criminal justice system might not have engaged in such behavior if they had been receiving adequate and appropriate mental health treatment (20).

In 1939 Penrose (21) advanced the thesis that a relatively stable number of persons are confined in any industrial society. Using prison and mental hospital census data from 18 European countries, Penrose found an inverse relationship between prison and mental hospital populations. He theorized that if one of these forms of confinement is reduced, the other will increase. According to this theory, where prison populations are extensive, mental hospital populations will be small, and vice versa. Thus if there is room in prisons and a shortage of hospital beds, many mentally ill persons who come to the attention of law enforcement might well be directed to the criminal justice system. Another corollary of this theory is that if civil commitment is reduced, involvement with the criminal courts will increase (22).

Proportion of incarcerated persons with mental illness

The Bolton Study (23), in 1976, was one of the first extensive and methodologically sound attempts to determine the percentage of county jail inmates with mental illness. In a five-county combined sample of 1,084 adults in California county jails, 6.7 percent were psychotic and 9.3 percent were judged to have nonpsychotic mental disorders, not including personality disorders. For Los Angeles County, the figures were 7.8 percent psychotic and 5.7 percent nonpsychotic.

In a more recent systematic study, Teplin and her coworkers (24) interviewed 728 randomly selected male admissions to the Cook County jail in Chicago. Using a structured psychiatric interview, they found that 6.4 percent met diagnostic criteria for schizophrenia, mania, or major depression. In a second study of women entering a county jail in Chicago, Teplin and her colleagues (25) found that 15 percent had severe psychiatric disorders within the previous six months, 1.8 percent had schizophrenia or a schizophreniform disorder, 2.2 percent were manic, and 13.7 percent had major depression. Guy and associates (26) interviewed 96 randomly selected admissions to the Philadelphia city jail and found that 14.6 percent had schizophrenia or manic-depressive illness.

With regard to state prisons, in a 1987 Michigan study of 1,070 state prison inmates carefully selected through a stratified random sampling procedure, 2.8 percent were found to have schizophrenia, 5.1 percent to have major depression, and 3.8 percent to have bipolar disorder or mania (27). Jemelka and associates (28) used the Diagnostic Interview Schedule with 109 inmates in the state of Washington and found prevalence rates of 1.1 percent for schizophrenia, 10 percent for major depression, and 3.7 percent for mania. Similar rates were found in California and Ohio prisons (29). Steadman and coworkers (30) studied a random sample of 3,332 inmates representing 9.4 percent of New York's general prison population, as well as 352 of the 360 inmates in the prisons' mental health units. They found that 8 percent of the sample had severe psychiatric functional disabilities that clearly warranted some type of mental health intervention, and another 16 percent had significant mental disabilities that required periodic services (specific diagnoses were not given).

Generally, clinical studies suggest that 10 to 15 percent of persons in state prisons have severe mental illness (29). It may be that in recent years, correctional staff have become better able to recognize signs of mental disturbance and, as a result, refer more of these individuals to mental health professionals. Thus better recognition may also contribute to the prevalence rate of inmates identified as mentally ill.

The magnitude of the problem can be seen when we multiply the percentages of mentally ill persons in jails and prisons by the number of inmates. For instance, in 1995 there were more than 483,000 persons in jails and more than 1,587,000 persons in state and federal prisons (31). Thus even a small percentage of such large populations represents a very significant number of mentally ill persons in jails and prisons.

The large number of mentally ill individuals in jails and prisons has presented serious problems for correctional staff. Gibbs (32) noted that second to overcrowding the presence of inmates with psychological problems was the most serious concern for correctional personnel.

Description of the population

In a study of 102 male inmates of a county jail randomly selected from those referred by jail staff for psychiatric evaluation, 99 percent had previous psychiatric hospitalizations, and 92 percent had arrest records (75 percent for felonies) (5). Four-fifths exhibited severe and overt psychopathology, and more than three-

fourths met criteria for civil commitment. When arrested, more than a third were transients, and only 12 percent were employed. More than half were currently charged with felonies and 39 percent with crimes of violence. Thus this population is characterized by extensive experience with both the criminal justice system and the mental health system; severe, acute, and chronic mental illness; and poor functioning.

The same study also found that of those charged with misdemeanors, more than half had been living on the streets, on the beach, in missions, or in cheap hotels, compared with less than a fourth of those charged with felonies (5). Persons living in such places obviously have a minimum of community supports. The authors speculated that the less serious misdemeanor offense is frequently a way of asking for help. Still another factor may be that many uncared-for mentally ill persons may be arrested for minor criminal acts that are really manifestations of their illness, their lack of treatment, and the lack of structure in their lives. It was also observed that some inmates, even though overtly psychotic, had underlying antisocial personality problems that appeared to play a major role as causative factors in their alleged criminal behavior. Findings were comparable in a similarly selected sample of 101 inmates of a county jail for women (33).

Other studies have shown that a large proportion of mentally ill persons in a jail population were homeless before arrest and incarceration (34,35). For instance, one study in New York City found that homeless mentally ill persons were grossly overrepresented among defendants with mental disorders entering the criminal justice and forensic mental health systems for both violent and nonviolent offenses (35). Forty-three percent of the defendants with mental disorders were homeless at the time of the crime for which they were arrested. The rate of homelessness was 21 times higher in the overall sample of defendants with mental disorders than in the overall population of mentally ill persons in the city. Moreover, homeless defendants were significantly more likely to have been charged with victimizing strangers.

Current trends

It is often asserted that the number of mentally ill persons currently in our criminal justice system is larger than before deinstitutionalization (4,36, 37). This assertion is consistent with Penrose's theory described above. It can be argued that society's tolerance in the community of the deviant behavior of people with mental disorders appears to be limited. This limited tolerance is especially true for those who have direct contact with mentally ill persons, namely, the courts, families, and other citizens.

Society's tolerance in the community of the deviant behavior of people with mental disorders appears to be limited.

Many believe that if social control through the mental health system is impeded because of constraints such as fewer long-term state hospital beds, community pressure will result in placement of some of these persons in the criminal justice system.

In the 1970s, studies began to appear showing that the arrest rate for former psychiatric hospital patients was higher than that for the general population (38,39). Various attempts were made to account for the higher rate. Steadman and associates (9) concluded from their data that the increase was due almost entirely to the increased number of persons with arrest records being admitted to mental hospitals. They speculated that "persons who formerly would have been caught in the 'revolving cell door' are now bouncing back and forth between state hospitals and jails as solutions are sought in mental health treatment for what are usually nuisance behaviors or property offenses."

A related explanation in the late 1970s was the theory of the "psychiatricization" of criminals (8,37). This theory hypothesized that the increased rate of violent crime after hospital discharge was due to jail and prison overcrowding and that mental hospitals were increasingly admitting individuals formerly dealt with by the criminal justice system. On the other hand, a 1978 study in a California county showed that former hospital patients with no history of arrests when they entered the hospital were arrested roughly three times more often after discharge than the general county population and five times more often for serious violent crimes (40).

Another explanation for the increased arrest rate of former hospital patients is that a more criminal group of mentally ill individuals is now hospitalized as a result of the stricter criteria for civil commitment, which rely heavily on dangerousness (41). Finally, the relationship between mental illness and violence, as discussed below, may be another factor. Despite the arguments offered, sufficient evidence does not exist to settle these issues definitively.

An important question is whether the number of mentally ill persons in jails and prisons has increased since deinstitutionalization. A number of studies over the past several decades have purported to demonstrate an increase, but Teplin (17) perhaps said it best when she wrote, "It is concluded that the research literature, albeit methodologically flawed, offers at least modest support for the contention that the mentally ill are being [increasingly] processed through the criminal justice system." This evidence is largely clinical and inferential, and it is certainly highly suggestive. However, because of the lack of good studies of mentally ill persons in jails and prisons before deinstitutionalization, findings of research conducted since that time cannot be con-

sidered conclusive evidence that the number of mentally ill persons has increased.

Nevertheless, it appears that a greater proportion of mentally ill persons are arrested compared with the general population. One of the better studies suggesting this disproportionate rate was conducted by Teplin (11). Chicago policemen were observed over a 2,200-hour, 14-month period, and 1,382 police-citizen encounters were documented. The presence of psychiatric illness in a suspect was determined at the scene by a system that took into account behavioral symptoms and the environmental context. It was found that 27.9 percent of the suspects without mental disorders and 46.7 percent of the psychiatrically ill suspects were arrested.

Perhaps two of the more persuasive arguments that a higher proportion of persons with severe mental illness can be found in the criminal justice system since deinstitutionalization are the presence of large numbers of such persons now residing in our jails and prisons and the clinical observations of clinicians and researchers. It is the impression of clinicians and researchers that a large proportion of the severely mentally ill persons they see in jails and prisons are similar in almost every way to long-term patients in state hospitals before deinstitutionalization (42). Obviously, lifetime residents of state hospitals had little opportunity to commit crimes and to be arrested.

In a similar vein, it was observed even in the 1970s that more liberty for the traditional psychiatric hospital patient placed in the community, including the ability to refuse treatment, is likely an important factor in explaining the observed increased arrest rate and violence (39,43). As discussed below, it is generally the untreated mentally ill person who is more violent, particularly if substance abuse is involved.

Mental illness and violence

Until recently it was generally believed that persons with major mental illness such as schizophrenia and bipolar illness were not more likely to commit violent crimes than the general population (44). However, a growing body of evidence has shown a relationship between mental illness and violence, especially among persons who are psychotic and do not take their medications (45–53). This relationship is most striking in relatively nonviolent societies, such as in Scandinavia. For instance, Modrick and his colleagues (49) found that males in Denmark with a severe mental disorder who were admitted to a psychiatric hospital by age 44 represented only 5 percent of the total population of males but were responsible for about 30 percent of all the violent offenses committed by males. Likewise, female mental patients in Denmark constituted about 5 percent of the female population but were responsible for 50 percent of all the violent offenses committed by females. Similar findings were noted in Sweden (54).

Substance abuse also increases the risk of violent behavior, particularly in combination with severe mental illness (44,47,51,53,55,56). While it would appear that the vast majority of persons with serious mental illness are not more dangerous than the general population, the recent literature cited above suggests the existence of a subgroup that is more dangerous. It has been asserted that violent behavior by this subgroup stigmatizes mentally ill persons generally and that it will be difficult to reduce the stigma until the violence of this subgroup is addressed (4).

Causative factors

The factors most commonly cited as causes of mentally ill persons' being placed in the criminal justice system are deinstitutionalization and the unavailability of long-term hospitalization in state hospitals for persons with chronic and severe mental illness, more formal and rigid criteria for civil commitment, the lack of adequate support systems for mentally ill persons in the community, the difficulty mentally ill persons coming from the criminal justice system have gaining access to mental health treatment in the community, and a belief by law enforcement personnel that they can deal with deviant behavior more quickly and efficiently within the criminal justice system than in the mental health system (57,58). A factor less commonly discussed is the public's attitudes toward persons with mental disorders who commit crimes.

In an article about the homeless mentally ill population, Belcher (59) wrote that "a combination of severe mental illness, a tendency to decompensate in a nonstructured environment, and an inability or unwillingness to follow through with voluntary aftercare arrangements and take prescribed medication contributed to involvement with the criminal justice system. Wandering aimlessly in the community, psychotic much of the time, and unable to manage their internal control systems, these people found the criminal justice system was an asylum of last resort."

Deinstitutionalization. As noted, the belief that deinstitutionalization is a cause of mentally ill persons' being placed in the criminal justice system is a widely held theory for which some evidence exists (5,17). It can certainly be demonstrated that less room currently exists in state mental hospitals for chronically and severely mentally ill persons. In 1955 when the number of patients in state hospitals in the U.S. reached its highest point, 559,000 persons were institutionalized in state mental hospitals out of a total national population of 165 million. Now the figure is 72,000 for a population of more than 250 million. In about 40 years, the U.S. has reduced its number of occupied state hospital beds from 339 per 100,000 population to 29 per 100,000 on any given day (60). However, these figures may not accurately reflect the numbers of persons who receive highly structured 24-hour care because of the development and growth of a variety of community psychiatric facilities (many of them locked) in the various states that attempt to provide this kind of care (61).

In our opinion, deinstitutionalization set the stage for increasing numbers of mentally ill persons to enter the criminal justice system. Moreover, serious problems in implementing deinstitutionalization have often been encountered, such as inadequate or inappropriate outpatient treatment, insufficient community resources, and insufficient 24-hour highly structured psychiatric care fa-

cilities for those who need them. To the extent that deinstitutionalization has resulted in these problems, we believe that it is a significant factor accounting for the placement in jails and prisons of many mentally ill persons who would otherwise be treated in the community or in a hospital.

More restrictive civil commitment criteria. Many people believe that more stringent civil commitment criteria have contributed not only to deinstitutionalization but to an increased number of mentally ill persons in jails and prisons (57,59,62,63). In 1969 California's then-novel civil commitment law, the Lanterman-Petris-Short Act, went into effect. Within a decade every state and Puerto Rico made similar modifications in their commitment codes. Such a rapid and complete consensus among legislatures is virtually unprecedented. More important, it reflected a nearly universal view that past inattention to the rights of mentally ill persons needed to be corrected.

In effect, the new civil commitment laws accomplished three things. First, the laws changed the substantive criteria for commitment from more general criteria that simply embodied concepts of mental illness and need for treatment to more specific criteria that embodied either dangerousness resulting from mental illness or the incapacity to care for oneself. Second, the laws changed the duration of commitment from indeterminate and extensive periods to determinate and brief periods. Third, the new laws explicitly provided that persons civilly committed have rapid access to the courts, to attorneys, and, in some cases, to jury trials; this access ensured the kinds of due-process guarantees to civilly committed persons that criminal defendants had obtained over the previous decade (64).

These procedural safeguards and clear commitment standards resulted in fewer as well as shorter commitments. Thus many mentally ill individuals who would otherwise have been civilly committed by family or others were now left to reside in the community. Moreover, the civil commitment standard for dangerousness in some states such as Alaska (65), California (66), and Washington (67) becomes more restrictive when extended commitments are sought. Therefore only the most dangerous mentally ill persons remain hospitalized, and the less dangerous are discharged. The result is greatly increased numbers of mentally ill persons in the community who may commit criminal acts and enter the criminal justice system.

On the other hand, it has been observed that changes in civil commitment law have often not had in practice the impact intended by those who wrote them (68). These reforms have been resisted by judges, mental health professionals, families, and even attorneys when they were seen as shifting the focus away from patients' treatment needs. Thus in some instances more restrictive commitment laws may not have been an important cause of an increased number of mentally ill persons in jail.

Access to treatment. The availability, or lack of availability, of treatment resources in the community has three important aspects. First, it is clear that in most, though by no means all, jurisdictions in this country, mental health treatment, housing, and rehabilitation resources are insufficient to serve the very large numbers of mentally ill persons in the community (69). For instance, case management has come to be viewed as one of the essential components of an adequate mental health program (20,41,70). However, the criminal justice system is ill prepared to provide case management services to mentally ill persons leaving jails and prisons. In many jurisdictions, local mental health agencies have also been slow to provide these services to this population (58).

Second, community mental health resources may be inappropriate for the population to be served (25). For instance, mentally ill persons may be expected to come to outpatient clinics when the real need for a large proportion of this population is outreach services. Some service providers may lack the ability to provide the degree of structure required by many mentally ill offenders.

Third, mentally ill persons who have been in jail may not be able to gain access to community treatment even when it is available. These persons have been described as resistant to treatment, dangerous, seriously substance abusing, and "sociopathic" (58,62,71)—characteristics generally not considered desirable by most community mental health agencies. Further, since many of these agencies may not have the capability to provide the needed structure, limit setting, and safety for staff necessary to successfully treat these persons, their reluctance to treat them may be appropriate.

A large proportion of mentally ill persons who commit criminal offenses tends to be highly resistant to psychiatric treatment (57,62,72). They may refuse referral, may not keep appointments, may not be compliant with psychoactive medications, may not abstain from substance abuse, and may refuse appropriate housing placements. As Whitmer (3) has observed, attempts at outpatient treatment with such persons "take on the aspect of a contest that a woefully unprepared therapist must sooner or later forfeit." Hence, he used the term "forfeited patients" to emphasize that these persons are not just passively lost to treatment, but that mental health professionals have actively struggled to treat them and have had to acknowledge defeat.

Thus the mental health system finds these mentally ill offenders extremely difficult to treat and resists serving them (57,71). This reluctance extends to virtually all areas of community-based care, including therapeutic housing, social and vocational rehabilitation, and general social services (58). Moreover, many mentally ill offenders are intimidating because of previous violent and fear-inspiring behavior. Treating this group is very different from helping passive, formerly institutionalized patients adapt quietly to life in the community (73). Community mental health professionals are not only reluctant but may also be afraid to treat them, especially when measures are not adopted to ensure staff safety. Then these mentally ill persons are left for the criminal justice system to manage (71). On the other hand, we have seen outpatient facilities in which structure is provided, staff are protected, and

mental health and criminal justice staff closely collaborate; under such circumstances many of these persons are successfully treated.

The role of the police. A large proportion of acutely mentally ill persons come first to the attention of the police (74–77). Even if the police consider the problem to be mental illness, the mental health option can involve a number of problems and irritants. There may be long waiting periods in emergency rooms during which police officers cannot attend to other duties. Mental health professionals may question the judgment of police and refuse admission, or they may admit for only a brief hospital stay a person who just a short time before constituted a clear menace to the community (57, 78, 79).

On the other hand, the police know very well that if they refer a psychiatric case to the criminal justice system, the offender will be dealt with in a more systematic way. He or she will be taken into custody, will probably be seen by a mental health professional attached to the court or in the jail, and will probably receive psychiatric evaluation and treatment. Thus arrest is a response with which police are familiar, one over which they have more control, and one that they believe will lead to an appropriate disposition (57, 80). Moreover, when persons who are socially disruptive are excluded from psychiatric facilities, the criminal justice system becomes the system "that can't say no" (62).

With regard to minor offenses, a number of factors have been proposed to explain why a mentally ill person is arrested rather than taken to a hospital. A person who appears mentally ill to a mental health professional may not appear so to police officers who, despite their practical experience, have not had sufficient training in dealing with this population and are still lay persons in these matters (63, 81). Also, mental illness may appear to the police as simply alcohol or drug intoxication, especially if the mentally ill person has been using drugs or alcohol at the time of arrest. Still another factor is that in the heat and confusion of an encounter with the police and other citizens, which may include forcibly subduing the offender, signs of mental illness may go unnoticed (3).

In addition, law enforcement officers may be more inclined to take mentally ill persons to jail if they believe no appropriate community alternatives are available (82), a practice that has been referred to as "mercy booking." Although this practice may be viewed as unconstitutional, the vast majority of states have not enacted legislation against detaining nonCriminal mentally ill people in jail (19).

The demands of citizens also come into play. Many retail stores have a policy that anyone caught shoplifting should go to jail, and store managers

The criminal justice system appears to have little interest in decriminalizing persons with psychiatric disorders even though they represent a considerable burden to that system and utilize scarce resources.

are instructed to make a citizen's arrest and call the police without exception. In another kind of situation, people who have just been assaulted by a psychotic person are frequently not inclined to be sympathetic to their assailant even when mental disturbance is evident. Thus an angry citizen may insist on signing a citizen's arrest and having the person taken to jail.

Society's attitudes. The public has traditionally believed that any sentence other than prison is too lenient for serious offenders, even if they are mentally ill (83). Moreover, some view mental illness as volitional and perhaps a deliberate attempt to avoid punishment (84, 85). Still another important factor is the public's fear of mentally ill persons who commit criminal offenses.

The public's growing intolerance of perpetrators, whether mentally ill or not, is demonstrated by its acceptance of and desire for more restrictive detention laws for offenders. With respect to offenders with mental disorders, some states have repealed sexual psychopathology laws that permitted mental health treatment for sex offenders rather than criminal processing and imprisonment. Diminished capacity, which can be a factor in granting a more lenient sentence, has also been repealed in a number of states. Moreover, legislation has been passed whereby offenders with mental disorders in prison can have their periods of social control extended if they are identified as dangerous before their parole date or the expiration of their sentence. For example, in California mentally ill offenders considered to be dangerous (86) and sexually violent predators (87) are usually transferred on their parole date or on expiration of their sentence to state mental hospitals, where they are confined for treatment for renewable periods of one or two years. In our opinion, these laws reflect the attitudes of society toward mentally ill offenders.

Although psychiatric interventions exist in the criminal justice system, mentally ill persons are more strictly controlled in that system than are patients in psychiatric hospitals (57). Moreover, the criminal justice system, despite protestations to the contrary, appears to have little interest in decriminalizing persons with psychiatric disorders even though they represent a considerable burden and utilize scarce resources. In a thoughtful article, Laberge and Morin (57) observed that a general decriminalization of psychiatric cases would threaten the criminal justice system to its foundations because such an approach might be perceived as undermining the principle of equality of all before the law. This perception would exist even where criminal law recognizes mental disorders as conferring a special status.

Specific treatment of mentally ill persons in the criminal justice system is often seen as special treatment both by the general public and within the criminal justice system. For instance, the insanity defense is perceived by most Americans as a frequently raised defense, as well as a way to evade justice. However, studies have shown that this defense is seldom used and rarely successful (88,89). In addition, it has been demonstrated that persons who successfully use this defense may be detained for considerably longer periods than others convicted for the same offenses (90,91).

Moreover, it appears the criminal justice system is more inclined to interpret and deal with criminal behavior in terms of illness when the deviant person acknowledges the illness and is willing to undergo treatment for it (92). Clearly, the appropriateness of treating mentally ill offenders safely in the community should be assessed. However, undertaking successful treatment for this population can be daunting. For instance, Brelje (93) wrote that effective psychotherapy for mentally ill offenders involves the patient's insight, an awareness of vulnerability to or presence of a mental disorder, a realistic understanding of the nature of the mental illness, a motivation to change or prevent recurrence of symptoms, an acceptance of treatment goals and strategies, realistic personal goals, and the patient's awareness of his or her legal status and its meaning.

However, Laberge and Morin (57) have observed that many mentally ill offenders do not take responsibility for their illness or their offenses and do not acknowledge their need for treatment. They refuse a therapeutic relationship and refuse to take medication and keep appointments. Therefore, they are often not seen by society as persons who should be "excused" for their legal transgressions. It appears that despite the concern of mental health professionals and many family members about mentally ill persons in jail, the general public would show little support for not placing social controls on individuals who commit offenses and refuse to submit to treatment that sets limits on their behavior.

This criminalization of mentally ill persons who have committed minor offenses cannot be seen as resulting simply from the usual explanations of lack of long-term hospitalization, lack of adequate support systems in the community, difficulty in gaining entry into the mental health system, and more restrictive criteria for civil commitment. Another crucial factor is society's concern that criminal offenses be dealt with and that persons committing them be controlled and punished, especially if they are not clearly willing to accept the patient role.

Conclusions and recommendations

Much has been learned about what needs to be done to prevent mentally ill persons from being inappropriately placed in the criminal justice system and about how to treat them once they are there and after they are released into the community. What has been lacking is widespread and comprehensive implementation of interventions shown to be effective (29). Several of these strategies are summarized below.

Steps should be taken to prevent inappropriate arrest of mentally ill persons (94). The police are often the first to respond to emergencies involving people with severe psychiatric disturbances (75). However, the police may not always recognize a need for, or have access to, emergency psychiatric resources. Clearly, mental health expertise is needed at this point to prevent criminalization. There is a pressing need for formal training of police officers to help them better understand mental illness and to improve their attitudes toward individuals with mental disorders (81,95).

Mental health consultation provided to the police in the field can result in a response that combines the specialized knowledge and expertise of law enforcement and mental health professionals. Such an approach can greatly increase the number of mentally ill persons given appropriate access to the mental health system rather than inappropriately diverted to the criminal justice system. For example, an evaluation of psychiatric emergency teams consisting of police officers and mental health professionals found that the teams were able to deal with psychiatric emergencies in the field even with a population characterized by acute and chronic severe mental illness, a high potential for violence, a high prevalence of serious substance abuse, and long histories with both the criminal justice and the mental health systems (77). These teams took or sent almost all of the persons in crisis to the mental health system and not to jail.

For individuals who are arrested and placed in jail, it is generally recommended that the facility routinely screen all incoming detainees for severe mental disorder and that jail administrators negotiate programmatic relationships with mental health agencies to provide multidisciplinary psychiatric teams (24,78). These teams should be established inside jails to provide short-term crisis evaluation, treatment, and referral to a psychiatric hospital if necessary. The teams should include psychiatrists so that psychoactive medications can be prescribed.

Mentally ill detainees who have committed minor crimes, such as trespassing and disorderly conduct, should be diverted to the mental health system entirely, or at minimum for treatment. For instance, mental health teams should be readily available for consultation to the arraignment courts and especially to the municipal courts, where many acutely psychotic patients appear with very minimal criminal charges. Steadman and associates (96) found that only a small number of U.S. jails have diversion programs for mentally ill detainees. They also observed that objective data on the effectiveness of these programs are lacking. On the other hand, it has been found that court-mandated and -monitored treatment in lieu of jail was effective in obtaining a good outcome for chronically and severely mentally ill persons who committed misdemeanors (97).

Belcher (59) wrote that a system that relies solely on voluntary compliance may not provide adequate structure for mentally ill offenders. He and others (94,98–101) recommended such mechanisms as outpatient commitment, court-monitored treatment, treatment as a condition of probation

torship or supervision by agencies such as Oregon's Psychiatric Security Review Board (102). Freeman and Roesch (103) acknowledged that the court or parole board has a right to set conditions for release to the community that include mandatory treatment. Nevertheless, mental health professionals have an ethical and legal obligation to fully inform patients about the nature of the treatment and obtain their consent for it.

It is important to recognize that persons with mental disorders who are discharged from psychiatric or correctional institutions experience multiple problems that cannot be adequately treated in traditional community-based facilities (104,105). Thus placement in the community often results in rehospitalization or reincarceration (106). To reduce this cycle, assertive case management programs are recommended.

The great majority of mentally ill offenders need the basic elements of case management, which starts with the premise that each person has a designated professional with overall responsibility for his or her care (20,107). The case manager formulates an individualized treatment and rehabilitation plan with the participation of the mentally ill person and often the supervision of the court. As care progresses, the case manager monitors the mentally ill person to determine if he or she is receiving and complying with treatment, has an appropriate living situation, has adequate funds, and has access to vocational rehabilitation.

The case manager not only provides outreach services, but also serves as an advocate for the individual and makes sure that the mentally ill person is not drifting away from the supportive elements of such a network. An assertive case management program deals with clients on a frequent and long-term basis, using a hands-on approach that may necessitate meeting with clients "on their own turf" or even seeing clients daily (106). This form of contact and familiarity with clients helps the case manager and client anticipate and prevent significant decompensation.

Important advances have been made in the violent behavior of severely mentally ill persons (108,109). Behavior therapy and pharmacotherapy—in particular, the use of the new atypical antipsychotic medications—are but a few examples. It is crucial that these modalities be widely implemented.

Mental health agencies in the community must be able to provide the degree of structure and limit setting needed by mentally ill offenders, as well as ensure the safety of staff. When highly structured 24-hour care is required, it should be provided.

The role of family members is an important aspect in the care of mentally ill offenders. Often overlooked are family members' needs for guidance and support. Families should be instructed in ways to help stabilize their relative (107). They should also be involved in support programs to help them during crises and in self-help programs so they can benefit from the experience of other families in similar situations (110).

We believe that a significant increase in mental health services for severely mentally ill persons, from outpatient treatment and case management to highly structured 24-hour care, would result in far fewer mentally ill persons' committing criminal offenses. Thus one of our most important recommendations is for increased mental health services. The criminal justice system should not be viewed as an appropriate substitute for the mental health system. Moreover, it has been our experience that an enormous stigma is attached to people who have been categorized as both mentally ill and an offender, and it is thus extremely difficult to place them in community treatment and housing. The difficulty is even greater when they have been in a forensic hospital.

Clearly, many mentally ill persons who commit criminal offenses present formidable challenges to treatment because of their treatment resistance, poor compliance with antipsychotic medications, potential dangerousness, high rate of substance abuse, and need for structure. To a large extent, the public mental health system has given up on them and allowed them to become the responsibility of the criminal justice system. We believe that [illegible] contribute to successful treatment of this population.

Implementing these recommendations would mean tailoring mental health services to meet the needs of mentally ill offenders and not treating them as if they were compliant, cooperative, and in need of a minimum of controls. The lives of a large proportion are characterized by chaos, dysphoria, and deprivation as they try to survive in a world for which they are ill prepared. They cry out for treatment and for structure, and we believe it is the obligation of the mental health system to provide it. If effective and appropriate interventions are provided, these individuals may not only improve psychiatrically but may also engage in considerably less criminal behavior. ♦

References

1. Swank G, Winer D: Occurrence of psychiatric disorders in a county jail population. American Journal of Psychiatry 133:1331–1333, 1976
2. Stelovich S: From the hospital to the prison, a step forward in deinstitutionalization? Hospital and Community Psychiatry 30:618–620, 1979
3. Whitmer GE: From hospitals to jails: the fate of California's deinstitutionalized mentally ill. American Journal of Orthopsychiatry 50:65–75, 1980
4. Torrey EF: Out of the Shadows: Confronting America's Mental Illness Crisis. New York, Wiley, 1997
5. Lamb HR, Grant RW: The mentally ill in an urban county jail. Archives of General Psychiatry 39:17–22, 1982
6. Abramson MF: The criminalization of mentally disordered behavior: possible side-effect of a new mental health law. Hospital and Community Psychiatry 23:101–105, 1972
7. Steury EH: Specifying "criminalization" of the mentally disordered misdemeanant. Journal of Criminal Law and Criminology 82:334–359, 1991
8. Cocozza JJ, Steadman HJ, Melick ME: Trends in violent crime among ex-mental patients. Criminology 16:317–331, 1978
9. Steadman HJ, Cocozza JJ, Melick ME: Explaining the increased arrest rate among mental patients: the changing clientele of state hospitals. American Journal of Psychiatry 135:816–820, 1978
10. Schneeman EA, Kobrin S: Exposure of community mental health clients to the criminal justice system: client criminal or patient prisoner, in Mental Health and Criminal Justice. Edited by Teplin L. Beverly Hills, Calif, Sage, 1984

11. Teplin LA: Criminalizing mental disorder: the comparative arrest rate of the mentally ill. American Psychologist 39:794–803, 1984

12. Dickey W: Incompetency and the nondangerous mentally ill client. Criminal Law Bulletin 16:22–40, 1980

13. Hochstedler E: Criminal prosecution of the mentally disordered. Law and Society Review 20:279–292, 1986

14. Hochstedler E: Twice-cursed? The mentally disordered defendant. Criminal Justice and Behavior 14:251–267, 1987

15. Arvanites K: The impact of state mental hospital deinstitutionalization on commitments for incompetency to stand trial. Criminology 26:307–320, 1988

16. Steadman HJ, Vanderwyst D, Ribner S: Comparing arrest rates of mental patients and criminal offenders. American Journal of Psychiatry 135:1218–1224, 1978

17. Teplin LA: The criminalization of the mentally ill: speculation in search of data. Psychological Bulletin 94:54–67, 1983

18. ABA Criminal Justice Mental Health Standards. Washington, DC, American Bar Association, Criminal Justice Standards Committee, 1986

19. Ogloff RP, Finkelman D, Otto RK, et al: Preventing the detention of non-criminal mentally ill people in jails: the need for emergency protective custody units. Nebraska Law Review 69:434–471, 1990

20. Dvoskin JA, Steadman HJ: Using intensive case management to reduce violence by mentally ill persons in the community. Hospital and Community Psychiatry 45:679–684, 1994

21. Penrose L: Mental disease and crime: outline of a comparative study of European statistics. British Journal of Medical Psychology 18:1–15, 1939

22. Stone AA: Comment [on reform of laws related to incompetency to stand trial]. American Journal of Psychiatry 135:61–63, 1978

23. Report to the California State Legislature. Sacramento, Calif, Arthur Bolton Associates, Oct 1976

24. Teplin LA: The prevalence of severe mental disorder among male urban jail detainees: comparison with the Epidemiologic Catchment Area program. American Journal of Public Health 80:663–669, 1990

25. Teplin LA, Abram KM, McClelland GM: Prevalence of psychiatric disorders among incarcerated women. Archives of General Psychiatry 53:505–512, 1996

26. Guy E, Platt JJ, Zwerling I, et al: Mental health status of prisoners in an urban jail. Criminal Justice and Behavior 12:29–53, 1985

27. Neighbors HW: The prevalence of mental disorder in Michigan prisons. DIS Newsletter, Department of Psychiatry, Washington University School of Medicine, St Louis 7:8–11, 1987

28. Jemelka RP, Wiegand GA, Walker EA, et al: Computerized offender assessment: validation study. Psychological Assessment 4:138–144, 1992

29. Jemelka RP, Rahman S, Trupin EW: Prison mental health: an overview, in Mental Illness in America's Prisons. Edited by Steadman HJ, Cocozza JJ. Seattle, National Coalition for the Mentally Ill in the Criminal Justice System, 1993

30. Steadman HJ, Fabisiak S, Dvoskin J, et al: A survey of mental disability among state prison inmates. Hospital and Community Psychiatry 38:1086–1090, 1987

31. State and Federal Prisons Report Record Growth During Last 12 Months. Washington, DC, US Department of Justice, Bureau of Justice Statistics, Dec 1995

32. Gibbs JJ: Problems and priorities: perceptions of jail custodians and social service providers. Journal of Criminal Justice 11:327–349, 1983

33. Lamb HR, Grant RW: Mentally ill women in a county jail. Archives of General Psychiatry 40:363–368, 1983

34. Michaels D, Zoloth SR, Alcabes P, et al: Homelessness and indicators of mental illness among inmates in New York city's correctional system. Hospital and Community Psychiatry 43:150–155, 1992

35. Martell DA, Rosner R, Harmon RB: Base-rate estimates of criminal behavior by homeless mentally ill persons in New York City. Psychiatric Services 46:596–600, 1995

36. Palermo GB, Smith MB, Liska FJ: Jails versus mental hospitals: a social dilemma. International Journal of Offender Therapy and Comparative Criminology 35:97–106, 1991

37. Davis S: Assessing the "criminalization" of the mentally ill in Canada. Canadian Journal of Psychiatry 37:532–538, 1992

38. Zitrin A, Hardesty AS, Burdock ET, et al: Crime and violence among mental patients. American Journal of Psychiatry 133:142–149, 1976

39. Sosowsky L: Crime and violence among mental patients reconsidered in view of the new legal relationship between the state and the mentally ill. American Journal of Psychiatry 135:33–42, 1978

40. Sosowsky L: Explaining the increased arrest rate among mental patients: a cautionary note. American Journal of Psychiatry 137:1602–1605, 1980

41. Steadman HJ, Monahan J, Duffee B, et al: The impact of state mental hospital deinstitutionalization on United States prison populations, 1968–1978. Journal of Criminal Law and Criminology 75:474–490, 1984

42. Lamb HR: Treating the Long-Term Mentally Ill. San Francisco, Jossey-Bass, 1982

43. Grunberg F, Klinger BI, Grumet BR: Homicide and the deinstitutionalization of the mentally ill. American Journal of Psychiatry 134:685–687, 1977

44. Stone MH: Criminality and psychopathology. Journal of Practical Psychiatry and Behavioral Health 3:146–155, 1997

45. Monahan J: Mental disorder and violent behavior. American Psychologist 47:511–521, 1992

46. Torrey EF: Violent behavior by individuals with serious mental illness. Hospital and Community Psychiatry 45:653–662, 1994

47. Mulvey EP: Assessing the evidence of a link between mental illness and violence. Hospital and Community Psychiatry 45:663–668, 1994

48. Link BG, Stueve A: Evidence bearing on mental illness as a possible cause of violent behavior. Epidemiological Review 17:172–181, 1995

49. Mednick SA, Brennan P, Katila H: Mental illness, violence, and fetal neural development. Paper presented at the annual meeting of the American Psychiatric Association, New York, May 4–9, 1996

50. Junginger J: Psychosis and violence: the case for a content analysis of psychotic experience. Schizophrenia Bulletin 22:91–103, 1996

51. Hodgins S, Mednick SA, Brennan PA, et al: Mental disorder and crime: evidence from a Danish birth cohort. Archives of General Psychiatry 53:489–496, 1996

52. Marzuk PM: Violence, crime, and mental illness: how strong a link? Archives of General Psychiatry 53:481–486, 1996

53. Swanson J, Estroff S, Swartz M, et al: Violence and severe mental disorder in clinical and community populations: the effects of psychotic symptoms, comorbidity, and lack of treatment. Psychiatry 60:1–22, 1997

54. Hodgins S: Mental disorder, intellectual deficiency, and crime: evidence from a birth cohort. Archives of General Psychiatry 49:476–483, 1992

55. Steadman HJ: Risk factors for community violence among acute psychiatric inpatients: the MacArthur risk assessment project. Paper presented at the annual meeting of the American Psychiatric Association, San Diego, May 17–22, 1997

56. Fulwiler C, Grossman H, Forbes C, et al: Early-onset substance abuse and community violence by outpatients with chronic mental illness. Psychiatric Services 48:1181–1185, 1997

57. Laberge D, Morin D: The overuse of criminal justice dispositions: failure of diversionary policies in the management of mental health problems. International Journal of Law and Psychiatry 18:389–414, 1995

58. Jemelka RP, Trupin EW, Chiles JA: The mentally ill in prisons: a review. Hospital and Community Psychiatry 40:481–491, 1989

59. Belcher JR: Are jails replacing the mental health system for the homeless mentally ill? Community Mental Health Journal 24:185–195, 1988

60. Resident Patients in State and County Mental Hospitals, 1994 Survey. Rockville, Md, Center for Mental Health Services, Survey and Analysis Branch, 1994

61. Lamb HR: The new state mental hospitals in the community. Psychiatric Services 48:1307–1310, 1997

62. Borzecki M, Wormith JS: The criminalization of psychiatrically ill people: a review with a Canadian perspective. Psychiatric Journal of the University of Ottawa 10:241–247, 1985

63. Husted J, Nehemkis A: Civil commitment viewed from three perspectives: professional, family, and police. Bulletin of the American Academy of Psychiatry and the Law 23:533–546, 1995

64. Lamb HR, Mills MJ: Needed changes in law and procedure for the chronically mentally ill. Hospital and Community Psychiatry 37:475–480, 1986

65. Alaska Statutes, Section 47.30.740

66. California Welfare and Institutions Code, Section 5300

67. Revised Code of Washington Annotated (West), Section 71.05.280

68. Appelbaum PS: Almost a revolution: an international perspective on the law of involuntary commitment. Journal of the American Academy of Psychiatry and the Law 25:135–147, 1997

69. Lamb HR: Public psychiatry and prevention, in Textbook of Psychiatry, 3rd ed. Edited by Hales RE, Yudofsky SC, Talbott JA. Washington, DC, American Psychiatric Press, in press

70. Kanter J (ed): Clinical Studies in Case Management. New Directions for Mental Health Services, no 65:1–114, 1995

71. Draine J, Solomon P, Meyerson AT: Predictors of reincarceration among patients who received psychiatric services in jail. Hospital and Community Psychiatry 45:163–167, 1994

72. Lamb HR: Incompetency to stand trial: appropriateness and outcome. Archives of General Psychiatry 44:754–758, 1987

73. Bachrach LL, Talbott JA, Meyerson AT: The chronic psychiatric patient as a "difficult" patient: a conceptual analysis. New Directions for Mental Health Services, no 33:35–51, 1987

74. McNiel DE, Hatcher C, Zeiner H, et al: Characteristics of persons referred by police to the psychiatric emergency room. Hospital and Community Psychiatry 42:425–427, 1991

75. Zealberg JJ, Christie SC, Puckett JA, et al: A mobile crisis program: collaboration between emergency psychiatric services and police. Hospital and Community Psychiatry 43:612–615, 1992

76. Way BB, Evans ME, Banks SM: An analysis of police referrals to 10 psychiatric emergency rooms. Bulletin of the American Academy of Psychiatry and the Law 21:389–397, 1993

77. Lamb HR, Shaner R, Elliott DM, et al: Outcome for psychiatric emergency patients seen by an outreach police–mental health team. Psychiatric Services 46:1267–1271, 1995

78. Lamb HR, Schock R, Chen PW, et al: Psychiatric needs in local jails: emergency issues. American Journal of Psychiatry 141:774–777, 1984

79. Rogers A: Policing mental disorder: controversies, myths and realities. Social Policy and Administration 24:226–236, 1990

80. Holley HL, Arboleda-Florez J: Criminalization of the mentally ill: I. police perceptions. Canadian Journal of Psychiatry 33:81–86, 1988

81. Husted JR, Charter RA, Perrou MA: California law enforcement agencies and the mentally ill offender. Bulletin of the American Academy of Psychiatry and the Law 23:315–329, 1995

82. Ogloff RP, Otto RK: Mental health interventions in jails, in Innovations in Clinical Practice. Edited by Keller P, Heyman S. Sarasota, Fla, Professional Resource Exchange, 1989

83. Petersilia J: Expanding Options for Criminal Sentencing. Santa Monica, Calif, Rand, 1987

84. Perr IN: The insanity defense: the case for abolition. Hospital and Community Psychiatry 36:51–54, 1985

85. Johnson PE: The turnabout in the insanity defense, in Crime and Justice: An Annual Review of Research, vol 6. Edited by Tonry M, Morris N. Chicago, University of Chicago Press, 1985

86. California Penal Code, section 2962

87. California Welfare and Institutions Code, section 6600

88. Pasewark RA, Pantle M: Opinions about the insanity plea. Journal of Forensic Psychology 8:63–67, 1981

89. Sales B, Hafemeister T: Empiricism and legal policy on the insanity defense, in Mental Health and Criminal Justice. Edited by Teplin L. Beverly Hills, Calif, Sage, 1984

90. Pasewark RA: A review of research on the insanity defense. Annals of the American Academy of Political and Social Science 484:100–114, 1986

91. Golding S, Eaves D, Kowaz A: The assessment, treatment, and community outcome of insanity acquittees: forensic history and response to treatment. International Journal of Law and Psychiatry 12:149–179, 1989

92. Conrad P, Schneider JW: Deviance and Medicalization: From Badness to Sickness. St Louis, Mosby, 1980

93. Biehe TB: Problems of treatment of NGRIs in an inpatient mental health system. Paper presented at a meeting of the Illinois Association of Community Mental Health Agencies, Chicago, 1985

94. Husted JR: The last asylum: the mentally ill offender in the criminal justice system, in New Directions in the Psychological Treatment of Serious Mental Illness. Edited by Marsh DT. Westport, Conn, Praeger, 1994

95. Murphy GR: Managing Persons With Mental Disabilities: A Curriculum Guide for Police Trainers. Washington, DC, Police Executive Research Forum, 1989

96. Steadman HJ, Barbera SS, Dennis DL: A national survey of jail diversion programs for mentally ill detainees. Hospital and Community Psychiatry 45:1109–1113, 1994

97. Lamb HR, Weinberger LE, Reston-Parham C: Court intervention to address the mental health needs of mentally ill offenders. Psychiatric Services 47:275–281, 1996

98. Swanson JW, Swartz MS, George LK, et al: Interpreting the effectiveness of involuntary outpatient commitment: a conceptual model. Journal of the American Academy of Psychiatry and the Law 25:5–16, 1997

99. Hoffman BF: The criminalization of the mentally ill. Canadian Journal of Psychiatry 35:166–169, 1990

100. Miller RD: An update on involuntary civil commitment to outpatient treatment. Hospital and Community Psychiatry 43:79–81, 1992

101. Clear TR, Byrne JM, Dvoskin JA: The transition from being an inmate: discharge planning, parole, and community-based services for offenders with mental illness, in Mental Illness in America's Prisons. Edited by Steadman HJ, Cocozza JJ. Seattle, National Coalition for the Mentally Ill in the Criminal Justice System, 1993

102. Rogers JL, Bloom JD, Manson S: Oregon's innovative system for supervising offenders found not guilty by reason of insanity. Hospital and Community Psychiatry 33:1022–1023, 1982

103. Freeman RJ, Roesch R: Mental disorder and the criminal justice system: a review. International Journal of Law and Psychiatry 12:105–115, 1989

104. Stein LI, Test MA: Alternative to mental hospital treatment. Archives of General Psychiatry 37:392–397, 1980

105. Witheridge TF, Dincin J: The Bridge: an assertive outreach program in an urban setting. New Directions for Mental Health Services, no 26:65–76, 1985

106. Wilson D, Tien G, Eaves D: Increasing the community tenure of mentally disordered offenders: an assertive case management program. International Journal of Law and Psychiatry 18:61–69, 1995

107. Lamb HR, Weinberger LE: Therapeutic use of conservatorship in the treatment of gravely disabled psychiatric patients. Hospital and Community Psychiatry 44:147–150, 1993

108. Harris GT, Rice ME: Risk appraisal and management of violent behavior. Psychiatric Services 48:1168–1176, 1997

109. Buckley PF, Zalar YL, Singer B, et al: Aggression and schizophrenia: efficacy of risperidone. Journal of the American Academy of Psychiatry and the Law 25:173–181, 1997

110. Hylton JH: Care or control: health or criminal justice options for the long-term seriously mentally ill in a Canadian province. International Journal of Law and Psychiatry 18:45–59, 1995

Statement by Supervisor Jan Brewer

Task Force on Improving the Arizona Mental Health System

September 21, 1999

Mr. Chairman, once again let me begin by thanking you for allowing me the opportunity to testify before this Task Force. It is clear to me that everyone on this committee is actively participating and volunteering their time towards the common cause of assisting Arizona's mentally ill.

Before I begin today's presentation regarding the role of Maricopa County in providing services to the mentally ill, let me respond to Senator Grace's comments of two weeks ago and reiterate my previous testimony.

- Maricopa County conveyed 160 acres of land back in 1885 to the Territory of Arizona for the sole purpose of maintaining a hospital for the mentally ill. It is our belief that a failure to maintain a facility for the mentally ill at this site is a breach of the trusts' conveyance.

- This is not to say that the County is ready to take back control of the State Hospital. However, we do feel that continued neglect by the State to provide and accommodate housing for the mentally ill

can ultimately lead to serious problems for all involved: the families, Maricopa County, and the State.

- In addition, we believe the State Hospital was never intended to be used as a prison. The fact is, the increasing presence of the Department of Corrections at this site is a perfect example of breaching the trust. We hope the State would vigorously pursue options to move DOC away from the State Hospital grounds – thus freeing up desperately needed space.

Introduction: Maricopa County – Helping find a Solution

When I was first elected to represent Maricopa County, I didn't know a whole lot about the County's role in dealing with the mentally ill. I knew of the Arnold vs. Sarn case, and I knew that the jail was full of seriously mentally ill individuals. But I didn't know what services we provided or how we dealt with these detainees.

Today, I have a much better understanding of the County's role, and I've broken it down into 3 basic components:

1) Our role as a defendant in the Arnold vs. Sarn case,
2) Our criminal justice system.
3) Our role outside of criminal justice with the Probate Court and Public Fiduciary helping to determine whether an individual should be civilly committed.

Arnold vs. Sarn

With regards to Arnold vs. Sarn, this Task Force is probably already familiar with the obligations of Maricopa County, so I'll briefly discuss this area. As a defendant in this case, our County has a legal obligation to help provide services for seriously mentally ill individuals.

We are also stipulated to provide financial support, and to utilize our best efforts in developing programs to review the appropriateness of jail admissions and divert class members from inappropriate incarceration.

Through an Intergovernmental Agreement with ADHS, Maricopa County is required to transfer behavioral health funds and responsibility for services to persons with serious mental illness. We paid $23,963,397 towards that cause last year. The IGA also establishes the funding mechanism by which we transfer funding for non-SMI, general mental health and substance abuse to ADHS at a basic cost of $4,856,576. Thus our total Arnold vs. Sarn obligation last year totalled $28,819,973.

Criminal Justice

The second area of responsibility for Maricopa County is within our huge Criminal Justice system that includes adult and juvenile detainees. This includes: pretrial service for the seriously mentally ill. correctional health service in the jail, and post trial service.

Unfortunately, we are finding that due to a lack of adequate community treatment and hospital or housing alternatives, mentally ill individuals frequently default to treatment or institutionalization in the County's criminal justice system.

Adult Jail :

At any given time, there are 150 seriously mentally ill individuals identified by Value Options in the Maricopa County jails. We believe there is actually a significantly higher number of seriously mentally ill individuals that are in our jail but not identified by Value Options. In FY 99, there were 1,348 identified SMI's arrested, approximately 1/3 of which have a diagnosis of schizophrenia. And we provide psychiatric services to adults at two licensed inpatient units with an annual expenditure last year of **$1.9 million**.

[psychiatrists = $367,795, psychologist = $32,688
(don't counselors = $495,996, nursing = $748.154
read) pharmaceuticals = $255,367]

The first unit, Durango, is a 92 bed Inpatient Psychiatric Unit which houses acute females and provides services to stabilize them. It also

provides longer term care for both male and female chronic, more stable, patients.

In FY 98/99 – there were 636 admissions into Durango, with an average daily census of 41.23. *(not used to capacity as double bunking is limited as a matter of policy – 92 beds)*

Our second Psychiatric Unit is the Madison Inpatient Unit, a 120 bed facility which houses acute male patients.

In FY 98/99 – there were 1,234 admissions into Madison with an average daily census of 49. *(Again, double bunking is used on limited basis as a matter of policy)*

Both Durango and Madison prepare a large number of mental health petitions to commit people to treatment at our County Psych Annex, rather than release them into the community because of dangerous behavior. You may be interested to note that only 5 percent of those in these Psych units have a diagnosis of primary substance abuse.

The County's Correctional Health Service also provides: less intense service to chronic mentally ill patients, general counseling to inmates that need crisis intervention, and referral services upon discharge. Psychiatric staff also monitor stability in the mentally ill who are released from inpatient units. These services cost the County some $633,443.

Pre trial:

In addition to serving those individuals in our correctional health system within the jail, our court system is responsible for evaluating competency to stand trial..

When an individual is charged with a crime, be it for a misdemeanor or a major felony, they have the right to be competent at the time of trial. The court decides whether a defendant would be best restored to competency in the community or at ASH.

Last year, 150 restorations were ordered. Of those defendants, 137 were charged with felonies, and only 13 with misdemeanors. The Court ordered 144 of those to ASH to attempt restoration, and the remaining 6 were referred to outpatient. The success with outpatient restoration is variable, as the incentive for the defendant to get better and then go to trial is minimal. Of the 144 admitted to ASH, only 3 were then readmitted for continued treatment. The total cost to Maricopa County last year for all competency evaluations equalled $641,821.

It is important to note that for every one patient sent to ASH to restore competence, two patients are diverted out of our Criminal Justice system/Jail through civil commitment. Approximately, 25 SMI patients are 'diverted' from the system every month. The County

spends $596,806 on Transitional Living Centers to accommodate these civil commitments.

Post Trial

After the trial, the Criminal Justice System is then burdened with the responsibility for providing mental health services again. Our Adult Probation Department currently supervises 450 probationers diagnosed with a serious mental illness, with an additional 20 probationers on a waiting list. The local Regional Behavioral Health Authority only provides case management services to approximately half of these clients.

Many, if not most of the 450 probationers have co-occurring disorders of substance abuse and mental illness. Subsequently, they are too often deemed ineligible for SMI services under the guise that their symptoms are substance induced. This happens even when evidence exists to the contrary. Adult Probation officers will routinely provide extensive documentation of mental illness only to be told documentation is not necessary.

Thus, County Probation officers assigned to these caseloads are – by default – serving in the capacity of RBHA case managers, and less attention is ultimately provided to other populations. These populations include, but are not limited to sex offender treatment, substance abuse treatment and domestic violence programs.

The costs associated for such Probation case management (most of which is picked up by the Administrative Office of the Supreme Court) totalled $1,350,925 in FY 98/99. Remember, however that this figure does not include costs for incarceration due to decompensation! The costs to the County in time and resources has yet to be calculated Given this situation, ultimately, Maricopa County is forced to utilize our jail as a treatment center due simply to an inability to access SMI services in the community.

Let me also take a quick moment to also mention that Maricopa County has been aggressive in diverting offenders determined to be SMI by the RBHA from jail. We currently fund our own crisis stabilization unit known as our Transitional Living Center to stabilize some of our SMI's. Also, the City of Phoenix has a diversion program which serves an average of 25 people a month. Add to that another 38 clients a year being diverted out through our Federal GAINS grant and you see that Maricopa County is doing more for outpatient restoration programs than any other county in the state.

Juvenile

As you can see, the Adult costs are mounting up and we haven't even discussed our Juveniles in the criminal justice system.

At a cost of $172,950, Maricopa County conducted approximately 575 mental competency exams on juveniles, 105 of which were sent to restoration treatment. After these pretrial exams, our Durango and

Mesa Juvenile Detention Centers provide psycniatric care to juveniles at a cost of $78,000. Finally, our Juvenile Probation Department supervises the juvenile population with 12 positions at a cost of $523,741.

When it comes to serving the juveniles, it is our experience that juveniles who suffer from mental illness spend about 4 times as long in detention and require significantly more service before disposition of their petition for delinquincy. This represents a further additional cost to the County of $ 903,000, and a total cost for Juvenile service of $1,426,741.

Civil

The County's third area of responsibility is the process of Probate Court and Public Fiduciary to help determine whether an individual should be civilliy committed.

We discussed the pretrial process for mentally ill detainees that may be restorable to competency. What about those detainees which the Court determines are not competent and cannot be restored to competency? For these individuals, the charges MUST be dismissed. At that point, the defendant can either be civilly committed or released back to the community. Of course, the County is also responsible for other civil commitments outside the criminal justice process as well.

There are four judicial officers that hear mental health matters and sign mental health orders. The cost of their services and that of support staff is $103,512 per year.

The Maricopa County Public Fiduciary has provided guardianship and/or conservatorship services for 348 persons with a mental health diagnosis in the last year. These required services include mental health treatment decisions, medical decisions, placement issues and decisions, advocacy on behalf of the client, client visitation, coordination of services and the management of their benefits and financial affairs. The average annual cost to the Public Fiduciary's budget is $1,004,676.

Summarize County roles

To summarize the major areas of responsibility for Maricopa County:

1) We're paying $28 million as part of the Arnold vs. Sarn legal obligation to provide mental health care.

2) Criminal Justice, which includes
   - Providing psychiatric treatment in our jail and juvenile detention centers.
   - Evaluation of competency.
   - Probation service.

3) Duties to help determine civil commitment within our Probate Court and Public Fiduciary.

Hospital

There are also non-legal costs incurred by the County which should be mentioned. The cost of the psych unit at the Maricopa Medical Center is $13.2 million per year. We receive a reimbursement of $11.7 million leaving a shortfall of about $1.5 million a year for the hospital.

Conclusion

The final message I want to leave with you today, is that there is a clear lack of interface between criminal justice and the behavioral health system. As you can see by the number of Severly Mentally Ill individuals that are ending up in our criminal justice system, community services are not adequately addressing the problem. And as I mentioned before, far too many are falling through the cracks after leaving our criminal justice system.

In my mind, the responsibility for case management of severely mentally ill patients, is with the RBHA, and not the Jail. The RBHA's case managers know the patients better than we do, and should be doing more to assist them. This is especially true after the patient is out of our criminal justice system and put on probation.

Ultimately, I believe the County is doing a good job of providing service. Yet without an inter-connected, cooperative effort between

the State, the Arizona State Hospital, the Regional Behavioral Health Authority, and the County; our system of providing mental health care will fail

Example: Andrew Frisk

Funding Provided to SMI Populations within Maricopa County

A. County General Government

The IGA between Maricopa County and ADHS pursuant to Arnold vs. Sarn:

Services to the SMI population (This cost is adjusted annually based on the cost of delivering services)	$23,963,397
Services to the non-SMI population, general mental health and substance abuse (This cost has stayed the same)	$ 4,856,576
Total	**$28,819,973**

B. Adult Criminal Court

There is little doubt that community programs and treatment for the mentally ill can effect rates of incarceration. Because of a lack of adequate community treatment and hospital or housing alternatives mentally ill individuals frequently default to treatment or institutionalization in the criminal justice system.

When an individual is charged with a crime be it for a misdemeanor or a major felony, they have the right to be competent at the time of trial. If after evidence is presented the court believes that the defendant is not competent and cannot be restored to competency the charges MUST be dismissed. At that point the defendant can be civilly committed or simply released to the community.

If a patient is determined to be restorable to competency then the court decides whether the defendant would be best restored in the community or at ASH. In the great majority of the cases in Maricopa County the defendants are in jail and have not been able to make bond or are unable to be released from custody for other reasons; the issue of release to the community is determined apart from competency issues. In virtually all cases where a defendant is in custody that custody status is not changed and the defendant will be ordered to ASH for an attempt at restoration.

If a defendant is determined by ASH to be not restorable then the individual is dealt with as if never assigned to ASH (i.e., the individual is either released to MMC for civil commitment proceedings or to the 'streets.')

The county pays for outpatient restoration on a fee for service basis. Success with outpatient restoration is variable since the incentive to get better and then go to trial is minimal.

Presently there are approximately 12,500 SMI RHBA designated patients in Maricopa County with a capitated rate of approximately $6800 per SMI patient per year paid the RBHA for services.

At any given time there are approximately 150 **identified** SMI individuals within the jail. All but 13 of 150 defendants were charged with felonies. In total, 3 defendants were readmitted to ASH for continued treatment. In FY 98/99 there were 1,348 **identified** SMIs incarcerated. Approximately 1/3 have a diagnosis of schizophrenia with 20% being bipolar. Approximately 10% are diagnosed with depression with the remaining numbers covering a panoply of diagnoses.

Program costs:

Adult Rule 11	$ 120,950
Juv Ment Comp	$ 172,950
No-Shows (adult and juv)	$ 36,600
State Hospital for patients[1]	$ 114,243
Invoices	$ 67,000
Total	**$ 511,743**

Staff costs for FY98/99 are as follows:

Professional Contracts	$ 193,900
Forensic Staff Salaries	$ 69,618
Commissioner Salaries	$ 30,510
Forensics Database	$ 30,000
Total	**$ 324,028**

C. **Correctional Health Services**
Psychiatric Services

1. **Juvenile Detention**

Area	Category	FY 99 Annual Expenditure	Unit of Measure	Annual # Units	FY 99 Daily Expenditure
Juvenile	Psychiatrists	$78,000	Encounters	1,546	$50.45
	Psychologists	0			
	Counselors	0			
	Nursing	0			
	Pharmaceuticals				
	TOTAL	$78,000		1,546	$50.45

Correctional Health Services (CHS) provides 20 hours per week of psychiatric care to juveniles in the Durango and Mesa Juvenile centers. This psychiatrist is available on an emergency basis Monday through Friday from 8:00-5:00. The following services are provided:

- On-site evaluations and assessments for ongoing continuing care

[1] In July, we paid for patients who remained too long after the court received the report.

- Emergency assessments for psychiatric/behavioral problems
- Telephone support and consultations with nursing staff
- Medication adjustments
- Consultations with Probation, ABS, outside providers and parents
- Recommendations for care after release from Detention.

2. Adult Population

The average daily population in the Maricopa County jails in FY99 was 7,065. On September 14, 1999, the population was 6,498 with 1,567 of those being sentenced inmates and the remaining 4,931 being pre-trial.

a) Adult Inpatient

CHS operates two (2) licensed psychiatric inpatient units. On the psych units, counselors see the patients daily; psychiatrists see them at least once per week or more often as needed. Routine staffings are held daily and staffings that are more extensive are held every 30 days.

Area	Category	FY 99 Annual Expenditure	Unit of Measure	Annual # Units	FY 99 Daily Expenditure
Adult – Inpatient	Psychiatrists	$367,795	Avg. daily	88	$59.15
	Psychologists	$32,688	Census		
	Counselors	$495,996			
	Nursing	$748,154			
	Pharmaceuticals	$255,367			
	TOTAL	$1,900,000		88	$59.15

1) D2, Durango Inpatient Psychiatric Unit:

- Licensed 92 bed facility (not used to capacity – double bunking is used on a limited basis as a matter of policy)
- FY99 total number of admissions: 636
- FY99 total number of discharge: 609
- FY99 Average daily census: 41.23 days
- Houses acute females and provides services to stabilize them. Also provides longer-term care for both male and female chronic, more stable patients. Services include medication education, group counseling, limited behavioral management programming as well as discharge planning. Has a "kinder, gentler pod" which strives to provide a protective environment for those with special needs (developmentally disabled). The unit prepares a large number of mental health petitions to commit people to treatment to the County Psych Annex rather than release into the community because of dangerous behavior.

2) 63, Madison Inpatient Psychiatric Unit:

- Licensed 120 bed facility (not used to capacity – double bunking is used on a limited basis as a matter of policy)

- FY99 total number of admissions: 1234
- FY99 total number of discharges: 1229
- FY99 Average daily census: 49 days
- Houses acute male patients and provide various psychiatric services to stabilize the patients including medication stabilization. Does a large number of mental health petitioning to commit people to treatment because of dangerous behavior.

The general composition of psychiatric units by diagnosis is:

Dually diagnosed:	70%
AXIS II:	5%
Primary substance abuse:	5%
AXIS I:	20%

b) Adult Outpatient

Area	Category	FY 99 Annual Expenditure	Unit of Measure	Annual # Units	FY 99 Daily Expenditure
Adult – Outpatient	Psychiatrists*	$493,908	Encounters	19,293	$33.71
	Psychologists	0			
	Counselors	$60,832			
	Nursing	0			
	Pharmaceuticals	$95,703			
	TOTAL	$650,443		19,293	34

***This number includes $17,000 for remanded juveniles**

CHS also provides less intense services to chronic mentally ill patients, general counseling to inmates needing crisis intervention and referral services upon discharge to inmates in the general population (outpatient). Outpatient psychiatric staff also monitor patients released from the inpatient units for stability.

Correctional Health Services FY99 Expenditures

Juvenile	
Adult – Inpatient	$ 78,000
Adult – Outpatient	$1,900,000
Total	$ 650,443
	$2,628,443

D. Adult Probation Department

Maricopa County Adult Probation currently supervises 450 probationers with a serious mental illness, with an additional 20 probationers on a waiting list. The local Regional Behavioral Health Authority provides case management services to approximately half of these clients. Probation Officers are finding their role changing from ensuring compliance with probation terms to locating mental health treatment for this population.

Many probationers have co-occurring disorders of substance abuse and mental illness. Often probationers requesting services are deemed ineligible for SMI services under the

guise that their symptoms are substance-induced, although they may have been incarcerated for several months. Once deemed ineligible, the client's only recourse is to file an appeal.

The appeal process through the local RBHA is not conducive to allowing the client or the client's advocate to present a fair case. Adult Probation Officers will routinely provide extensive documentation, only to be told documentation is not necessary.

Due to these issues, as well as an inability to find adequate housing for these individuals, Maricopa County Adult Probation has been placed in the situation of providing case management for this population. Maricopa County has established a jail diversion program used for stabilization and housing up to 25 clients with serious mental illness. The probation officers assigned to these caseloads are serving by default in the capacity of RBHA case managers. There are numerous other populations that could be served by redirecting the SMI related funding. Those include, but are not limited to, sex offender treatment, substance abuse treatment and domestic violence programs.

A breakdown of the costs associated with case management services for this population is as follows:

Personnel	$ 722,119
Transitional Living Center	$ 596,806
Psychiatric Services	$ 20,000
Training/Technical	$ 12,000
Total	**$ 1,350,925**

This figure does not include costs associated with incarceration of these individuals due to decompensation. Unfortunately, Maricopa County is forced to utilize the jail as a treatment center due to an inability to access SMI services in the community.

E. Maricopa County Juvenile Court

There were approximately 575 mental competency evaluations conducted on juveniles before the Court for a delinquent petitioned offense. The Office of Court Appointed Counsel (OCAC), reports $172,950 were spent for the mental competency evaluations. OCAC has reported an additional $36,000 spent on adult and juvenile "no shows" to an evaluation appointment, indicating most of the "no shows" are juveniles.

Juveniles referred to outpatient mental competency restoration programs numbered 105. Funds are appropriated to Maricopa County Juvenile Probation for outpatient restoration treatment by the Administrative Office of the Supreme Court. Currently, the AOC provides MCJPD $10.6 million dollars for treatment services for our entire probation population. On average, restoration outpatient treatment services are totaling $15,500 a month.

Outpatient restoration is provided within our detention facility when inpatient treatment is unavailable at the Arizona State Hospital. Of the 105 juveniles referred for outpatient restoration treatment, 20 were treated in our detention facility. Attached charts show following restoration treatment, 15% of petitions for delinquent offenses are dismissed and 3% continue on to be adjudicated. However, 82% of the cases are still pending restoration treatment.

The length of stay in detention is increased when dealing with a juvenile with mental health needs. In FY 98-99, the average length of stay in detention was 13 days with a daily cost of $80.00. The length of stay increases, as do the costs, when attempting to provide services to this population. As indicated by the graph, juveniles remain in detention as additional 42 days as a treatment plan is developed for them. The $80.00 daily cost is increased by $50.00, as reported by the Correctional Health Department in providing psychiatric and pharmaceutical services. Last FY there were 430 juveniles detained with mental health needs. At an additional $50.00 and an additional 42 days, the cost is **$903,000**.

The juvenile probation department has committed staff to supervise this specialized population. Currently the county funds 12 positions at a cost of **$523,741**.

Daily Detention Cost for SMIs	$ 903,000
Probation Personnel	$ 523,741
Total	**$1,426,741**

F. **Adult Probate Court**

From 1997 through 1998, there were substantial increases in both new mental health filings (28%) and hearings (20.6%.) Although statistics are not available that specifically document why these increases have occurred, it appears that a significant number of mentally ill individuals have not received treatment through the behavioral health system before reaching a crisis level that necessitated court-ordered evaluation and treatment.

There are four judicial officers that hear mental health matters and sign mental health orders. The cost of their services and that of support staff is **$103,512** per year. The substantial increases in both filings and hearings have resulted in judicial officers spending more time on mental health than in past years. If the situation can be avoided by mentally ill individuals receiving treatment prior to the individual reaching a crisis level, the filings and hearings should drop significantly and the judicial officers would then be able to allocate their time to Probate or the other divisions. This would reduce the need to hire additional judicial officers to perform tasks in Probate or the other divisions.

SMI FUNDING BREAKDOWN
FY98-99

		County	***State***
A.	Public Fiduciary	$ 1,004,676	$ 0
B.	Adult Probation Department	$ 12,000	$ 1,338,925[2]
C.	County General Government	$28,819,973	$ 0
D.	Adult Criminal Court	$ 805,771	$ 0
E.	Correctional Health Services	$ 2,628,443	$ 0
F.	Adult Probate/Mental Health Court	$ 103,512	$ 0
G.	Juvenile Court and Probation	$ 1,426,741	$ 186,000
	Total	$34,801,116	$ 1,524,925
	Grand Total		**$36,326,041**

[2] Pass through from Administrative Office of the Supreme Court.

MARICOPA COUNTY MENTAL HEALTH CARE ROLE

Appendix J 3 to Mental Health Task Force Report, November 30, 1999

I Arnold vs. Sam:

II Criminal Justice:

A. Adult Services

1. Maricopa County Jail (Correctional Health)
   a. Inpatient Psychiatric Units
   b. Outpatient (within Jail)

2. Maricopa County Superior Court
   a. Diversion Programs
   b. Evaluation/Restoration

3. Maricopa County Adult Probation
   a. By Default: Case Management

B. Juvenile Services

1. Maricopa County Juvenile Detention Centers (Correctional Health)

2. Maricopa County Superior Court
   a. Evaluation
   b. Extended Detention & Services

III Civil:

A. Probate Court
B. Public Fiduciary

ARNOLD V. SARN OBLIGATIONS

- **Both ADHS & Maricopa County are mandated to ensure a full continuum of behavioral health and mental health care for all class members.**

- **Maricopa County is to develop a program(s) designed to review the appropriateness of jail admissions and divert class members from inappropriate incarceration.**

IGA: Maricopa County shall pay

Services to the SMI population	=	$23,963,397
Services to the non-SMI population	=	$ 4,856,576
Total	=	**$28,819,973**

CORRECTIONAL HEALTH SERVICE:
Adult Psychiatric Units

DURANGO 92-bed Inpatient Psychiatric Unit:

- FY99 Total admissions: 636
- FY99 Total discharge: 609
- FY99 Average Daily Census: 41.23

- Houses: Acute females. Also provides longer-term care for both male and female chronic, more stable patients.

- Services: Medication education, group counseling, limited behavioral management programming, and discharge planning.

MADISON 120-bed Inpatient Psychiatric Unit

- FY99 Total Admissions = 1,234
- FY99 Total Discharges = 1,229
- FY99 Average Daily Census = 49

- Houses: Acute male patients.

- Services: Stabilize patients including medication. Large number of mental health petitioning to commit people to treatment because of general behavior.

Evaluation of Competency

FY 99 1,000 competency reports produced.
300 Full Rule 11 (Competency) evaluations conducted.

FY 99 150 Restorations ordered

- 137 charged with felonies
- 13 charged with misdemeanors

- 144 sent to Arizona State Hospital
- 6 referred to Outpatient for restoration

FY 99 Total Cost for all attempts to evaluate competency = $641,821

For every ONE patient sent to Ariz. State Hospital, TWO patients are diverted out of County Criminal Justice System through civil commitment.

ADULT PROBATION

450 Probationers

- Regional Behavioral Health Authority (Value Options): Provides case management to only ½.
- Most have co-occurring disorders of substance abuse and mental illness.
- Often deemed ineligible by Value Options for SMI services. (citing substance induced symptoms).
- Documented evidence of non-substance induced mental illness.
- County Probation Officers serving as RHBA case managers by default.
- Jail used as treatment center due to inability to access SMI services in the community.

MARICOPA COUNTY MENTAL HEALTH CARE ROLE

I Arnold vs. Sarn:	$28,819,973
II Criminal Justice:	
A. Adult Services	
1. Maricopa County Jail (Corr. Health)	
a. Inpatient Psychiatric Units	$ 1,900,000
b. Outpatient (within Jail)	$ 633,443
2. Maricopa County Superior Court	
a. Diversion Programs	
b. Evaluation/Restoration	$ 641,821
3. Maricopa County Adult Probation	
a. By Default: Case Management	$ 12,000
B. Juvenile Services	
3. Maricopa County Juvenile Detention Ctr. (Correctional Health)	$ 78,000
2. Maricopa County Superior Court	
a. Evaluation	$ 172,950
b. Community Monitoring	$ 523,741
c. Extended Detention & Services	$ 903,000
III Civil:	
A. Probate Court (4 officers)	$ 103,512
B. Public Fiduciary	$ 1,004,676
IV. Hospital Cost	$ 1,500,000
TOTAL COST:	**$36,293,116**

Maricopa County Answer to Task Force Questions from Staff

1. What is the size of the Psychiatric Unit in the Maricopa County Jail? Daily Census.

Answer: There are 2 psychiatric units at the jail, Durango and Madison.

Durango = 92 beds
Total admission = 636 (FY 99)
Avg. Daily census = 41 (policy of not usually double bunking)

Madison = 120 beds
Total admission = 1,234 (FY 99)
Avg. Daily Census = 49 (policy of not usually double bunking)

2. What is the current total number of prisoners in the County Jail?

Answer: The average daily population in the Maricopa County Jail in FY 99 was 7,005.

On September 14, 1999 we had a population of 6,498 (1,567 sentenced inmates and 4,931 pre trial detainees).

3. How many of these current prisoners have been assessed as mentally ill? How many are in treatment in the jail?

Answer: Our data reflects -- and is corroborated by County Departments -- at least 7 to 10 percent of our prisoners have been assessed as mentally ill.

4. What is the composition of the psychiatric Unit by diagnosis (Please differentiate between persons who are mentally ill with a co-existing substance abuse diagnosis and those who have a primary substance abuse problem.

Answer:

Dually diagnosed	**=**	**70%**
Personality Disorders (AXIX II)	**=**	**5%**
Primary Substance Abuse	**=**	**5%**
Major Mental Health Illness (AXIS I)	**=**	**20%**

5. At the time of arrest/detention, what number and percent of prisoners are enrolled in the Maricopa County RBHA? Please differentiate between persons enrolled as seriously mentally ill and those enrolled as general clients.

Answer: Probation supervises 450 with SMI & half are RBHA clients. In FY 99, 1,348 were arrested and identified as SMI by RBHA.

6. How many persons with mental illness were jailed last year in Maricopa County, statewide and nationally? Please advise on the trend over the past 5 years.

Answer: In FY 99, RBHA recognized 1,348.

7. How does Maricopa County compare with statewide or national statistics on a per 100,000 population basis?

Answer: National statistics show an average of 16.3 percent.

8. Based upon total annual number of adults arrested, how many and what percentage of prisoners/ defendants are sent to the Arizona State Hospital for restoration to competency. How many and what is the percentage of prisoners/defendants referred for outpatient restoration services?

Answer: 150 defendants were ordered for restoration to competency.
144 were sent to ASH.
6 were referred to outpatient services.

9. Please describe the outpatient restoration to competence services that currently exist in Maricopa County for adults and children. How many people are served by these programs on an annual basis? Please describe any plans for expansion of these programs.

Answer: Most misdemeanants who would otherwise require restoration services are diverted into other programs and charges are dropped. We are working to expand our outpatient restoration programs. We believe we are doing more than any other county.

For every 1 patient sent to ASH, <u>two</u> patients are diverted out of the criminal justice system/jail through civil commitment.

10. For the most recent 12 month period, please provide a breakdown of the types of offenses for which mentally ill persons have been incarcerated in Maricopa County.

Answer: Our RBHA, Value Options, would be the only entity which could provide this information.

11. How many individuals with mental illness are diverted by the Regional Behavioral Health Authority?

Answer: 25 per month + 38 annually. (About 28 per month average)

12. Do you think more could be diverted. What changes in service delivery do you see as necessary?

Answer: Yes. Maricopa County is introducing a new felony diversion program this year.

Changes: We would like to see RBHA take a larger role and we believe strongly that stronger communication and exchange of information is required.

13. For a recent 12 month period, please provide a breakdown of the disposition of persons returned to the jail following hospitalization at Arizona State Hospital for restoration to competence.

A. Determined not restorable
   1. Title 36 court ordered treatment
   2. Release, no court ordered treatment

B. Restored to competence
   1. Held for trial
      a. Found guilty, sentenced
      b. Found GEI
      c. Found innocent
      d. Released, time served
      e. Released, charges dropped
   2. Not held for trial, released
   3. Title 36 court ordered treatment
   4. Readmitted to ASH for RTC (same arrest)

Answer: 40 were found not restorable. 23 of which had previously gone to ASH. (28 = Title 36, 12 = released)

All patients returned to the court as competent go to trial or have the case settled - none are dismissed at that time and 3 were readmitted to ASH.

Approximately 28 patients committed (Title 36) after a finding of incompetence and non-restorability.

GEI defendants = 9 from Maricopa County.

Approximately 40% of all defendants sent to ASH for restoration are charged with Non-violent offenses. Less than 10 percent of patients sent to ASH face only misdemeanor charges.

Ultimate disposition - innocence, guilt, probation, jail, prison - unknown.

14. The data link between the Maricopa County Jail and ValueOptions has been reported to be an innovative way to quickly identify individuals who are enrolled in the RBHA. Has this system improved the coordination between the County Jail and the RBHA? Please describe.

Answer: While the system has improved, there needs to be a continuity of care and follow up by the RBHA.

15. Arizona is one of the few states that has an Offender's Council. Describe how this Council has improved services for this population.

Answer: This was in many ways the catalyst for our diversion program. Certainly we need to coordinate so as to get a full understanding of the statewide problem, and do this with the RBHA's participation.

STRATEGIC PLAN FOR HOUSING

August 2, 1999

Arnold v. Sarn
Office of the Court Monitor

Prepared by Nancy E. Diggs

In Cooperation With
ADHS and ValueOptions

STRATEGIC PLAN FOR HOUSING

I. INTRODUCTION

As required by the Supplemental Agreement, the Arizona Department of Health Services, ADHS, in collaboration with the Regional Behavioral Health Authority (RBHA), and the Arizona Department of Commerce (ADOC), prepared a draft strategic plan on housing services on March 1, 1999. The plaintiffs submitted comments to the draft on March 25, 1999. The parties met on April 1, 1999 to discuss the plan. The parties agreed that the plan: (1) did not address the full spectrum of housing needs of all class members; (2) only focused on the short term crisis caused by the termination of several HUD grants; and (3) only made provisions that certain other HUD programs might be available to offset the losses from these grants.

It was agreed by the parties that the Office of the Monitor would review all available information and re-draft a plan that would be recommended to the Court as provided by ¶18 of the Supplemental Agreement. This plan is now being submitted to the Court for its approval.[1]

II. SCOPE OF THE PLAN

The short term housing plan is designed to address the housing crisis related to the anticipated decrease in HUD funded housing units that currently serve class members. This plan describes those actions that must be taken to address this crisis within the next six to twelve months. It also sets forth administrative, organizational and preliminary planning initiatives which are designed to restructure the provision of housing support services for class members and provide an infrastructure to develop and implement a long term Strategic Housing Plan.

This plan includes strategies for the development of accessible and affordable housing provided through: (1) the private sector, either in homes owned or rented by class members, their families or peers; (2) private housing subsidized by state or federal agencies, through loan guarantees, tax credits, direct subsidies, or grant programs; (3) publicly developed and operated housing funded by state or federal agencies; (4) housing owned or leased by individuals with serious mental illness that also include support or other wrap-around services provided by other agencies; (5) housing rented or owned by private housing agencies, with support services funded or arranged by ADHS; and (6) residential settings operated by mental health providers which also offer and arrange support services in those settings.

Individuals with serious mental illness in Maricopa County need to have the housing necessary to ensure a stable living environment. This plan describes some of the strategies for addressing this need, regardless of the type or funding arrangement for

[1] Nothing in this strategic plan should be construed to require the ADHS to act in a manner contrary to the requirements of the Department Rules applicable to persons with Serious Mental Illness, A.A.C. Title9, Chapter 21.

that housing, and regardless of whether mental health support services are provided in or linked to the housing arrangements. It does not attempt to specify the precise quantity or type of housing which must be developed or maintained in order to meet the needs of all class members. This will be accomplished through a separate service development gap analysis plan and later refined through a consumer needs assessment in order to develop the long term strategic plan described in Section V below, which will be an amendment to this document.

This strategic plan is intended to:

1. Begin to define some of the obligations of ADHS to meet the housing needs of class members;
2. Identify a range of housing and residential support options for meeting those needs;
3. Describe the processes and methods for developing a sufficient array of housing options, through the creation of an infrastructure for planning and housing development; and
4. Delineate specific actions necessary to meet class members' needs for housing, through the creation and implementation of short term and long term strategic initiatives.

III. VALUES AND GUIDING PRINCIPLES

The values and guiding principles form the foundation of this plan. This plan was developed and will be implemented based on the following:

1. Adults with serious mental illness will have the opportunity to live in their own home with the flexibility of a service system, which responds to individual needs by increasing, decreasing and changing the support services as needed.
2. Stable and affordable housing enhances effective treatment and rehabilitation for the individual.
3. Transitional and flexible in-home support services are needed by class members to achieve and maintain success in community based living.
4. A complete range of housing options, with and without treatment supports, will be available to class members.
5. Class members will be offered housing choices and will have a voice in designing the supports needed in order to maintain their housing.
6. Clinically necessary services and supports will be available as needed regardless of where the person chooses to live.
7. Emphasis will be placed on permanent housing options or a client's *home*, rather than residential settings which require the client to move when the

level and/or intensity of treatment supports either need to increase or decrease.

8. Services and supports will be tailored to the individual rather than be pre-programmed or based on a "typical" client's needs.
9. The delivery of, or refusal to accept, treatment services will not jeopardize the person's home or living arrangement.
10. Clients will have sufficient access to emergency housing options when necessary.
11. ADHS has the responsibility to ensure a stable supply of accessible and affordable housing for class members, in need of housing assistance.
12. ADHS has the responsibility to develop, create and maintain a sufficient array of housing options and residential services necessary to meet the individual needs of class members.
13. ADHS is responsible to provide an adequate infrastructure and effective interagency processes in order to develop and maintain an adequate array of affordable, accessible housing and residential support options.
14. ADHS and the RBHA must have an adequate capacity of trained staff to establish this infrastructure, conduct the interagency linkages, and insure the development and maintenance of a sufficient array of accessible housing options.
15. As part of their Individual Service Plan (ISP), each class member will have a housing plan with provisions for emergency housing services.

IV. SHORT TERM PLAN

A. Need

At a national level the provision of behavioral health and housing services to persons with mental health disabilities is at a critical juncture. According to the National Technical Assistance Center for State Mental Health Planning, "The erosion of affordable housing stock, diminishing federal funds, shifts in control from the federal level to the state and local levels and the emergence of managed care are among the key challenges confronting the public behavioral health system that have contributed to the rapidly changing housing environment. Although these changes present significant challenges to the mental health and housing communities, they also represent opportunities to reshape public policy and to improve consumers' access to safe, decent and affordable community-based housing by creating new partnerships that explore ways to pool resources across housing and service systems." (Housing for Persons with Psychiatric Disabilities: Best Practices for a Changing Environment, pg. XI).

1. Current Housing

Housing Gaps

a. Treatment Alternatives

Gaps exist in the treatment and housing continuum, either because of lack of availability or lack of accessibility. It is important to realize that both approaches should work together to enhance housing options. Sometimes the only housing available has fewer services and support that the customer needs, but it is the only housing that is available.

b. Persons Leaving Correctional Facilities

Another population that also is difficult to house are persons with felony convictions or who are on probation. Often their corrections history precludes their ability to sign a lease, and makes it difficult for them to obtain jobs to help them pay for more independent types of housing. Those persons who are in treatment for substance abuse and who have a corrections history have tremendous difficulty locating housing.

c. Transitional Housing

Transitional housing for almost all populations is difficult to find and expensive. Transitional housing that combines transitional treatment interventions (preparation for de-institutionalization whether from treatment or correctional facility, or preparation for movement to a more independent living situation on the continuum outlined above) is not systematically available in the current array.

d. Consumers Who Use Alcohol or Drugs

Currently, most of the available housing is for persons who do not use alcohol, even on an occasional basis. Some of the agencies providing housing, add this condition to receiving housing, even though the tenants' usage of alcohol may not be abusive. This type of housing is sometimes classified as "dry" housing and alcohol use is not allowed. Also, neither "moist" (harm reduction treatment) and "wet" (active use of drugs and alcohol) housing is available. As a consequence of the lack of housing options, housing for substance abusing populations is especially scarce.

Clients Currently Housed in Inappropriate Living Situations

Besides the consumers who have no housing, some consumers are housed in "inappropriate living situations." Generally speaking, these tend to fall into one of three categories:

- Living in non-recovery-oriented environments, including many of the "Supervisory Care Homes" that tend to warehouse residents;
- Living in homeless shelters;
- Incarcerated, or leaving that system;
- Living with inappropriate partners (i.e., a recovering substance abuser living with active drug users); and/or
- Living in the Arizona State Hospital (ASH) or other higher levels of care because no lower levels or appropriate housing options are available.

All of these situations have very detrimental affects upon individuals and can cause behavioral health problems to worsen.

Currently in Maricopa County, nearly 1500 consumers receive housing assistance, however, there are few housing options available. Almost 1200 of these units are HUD funded. The majority of the options that are available represent the extremes of the housing continuum. Housing options are concentrated either in individual, independent, apartment living situations (sometimes with wrap-around services) or in 24-hour inpatient/residential care. Two other available alternatives are a few group homes and some semi-independent living environments. The majority of current options concentrate on providing housing for persons who live alone.

The following chart outlines the current housing units funded through HUD. The other major source of housing, Supervised Independent Living (SIL) are primarily funded through service dollars and are not included in the following chart. Dollar amounts are for the entire term of the (mostly) multi-year grants.

# of Units (Program)	Contract Amount	Services Provided
614 Shelter + Care (5 years)	$ 16,347,880	Rental Subsidy
152 Stargate (3 years)	$ 8,174,360	Rental Subsidy, Supportive Services & Operations
125 SHP (3 years)	$ 4,785,851	Rental Subsidy & Supportive Services
14 UMOM & Brookside (3 years)	$ 1,336,700	Operations & Supportive Services
130 ADHS – TXIX (1 year)	$ 1,347,780	Furniture and related independent living needs
75 HUD 811 (20 years)	Awarded to individual owners	Capital & Operating costs
1198 Total Units	**$ 31,992,571 Total Contract Amounts**	

All of the housing units in the above chart, with the exception of the HUD 811 units, are for homeless, seriously mentally ill persons. The HUD 811 units provide housing for seriously mentally ill persons, but without the requirement to meet homeless criteria.

Additionally, the RBHA contracts through its provider network for treatment services that also provide "housing." Two different levels of care fall into this category, including 24-Hr Basic Supervised Residential and Semi-Supervised Residential (Basic and Intensive). The RBHA also contracts for specific "ASH Reduction Services" that include housing. Projecting based on current contracted levels (units and rates), the RBHA will spend more than $5,589,000 per year in supporting persons in these settings. This is likely to be a conservative estimate, since the RBHA plans to increase capacity in these levels of care to decrease and eventually eliminate waiting lists.

B. Goals and Administrative Issues

Goal: Insure adequate administrative capacity to manage the housing dollars and programs that are in place.

1. Housing Administrative Agency

Since the current HUD housing programs require administration by a non-profit entity and the RBHA is a for-profit corporation, the RBHA has selected a non-profit agency to administer HUD programs. This agency will be the grant recipient, and will serve as the administrative manager of the housing process.

The RBHA will contract with the Housing Administrative Agency to ensure that the following core administrative and grant management tasks occur competently:

- Administration of current HUD housing grants including managing wait lists, monitor fiscal expenditures and program implementation, generating HUD reports and completing Annual Performance Reviews;
- Monitor performance of housing providers;
- Develop communication system with the RBHA, housing providers, and Clinical Teams to ensure proper placement and services for consumers;
- Process and pay provider claims within the same standards as the RBHA;
- Develop in association with the RBHA, communication, referral and problem resolution protocols;
- Assist in developing documentation systems to monitor service dollar match;

- Participate in the local Continuum of Care planning process and seek renewal and additional housing resources including housing development;
- Provide technical assistance to housing providers informing them of current housing programs, best practices and alternative service delivery methods;
- Monitor activities of the Tenant Advisory Council (TAC) and offer assistance and training as needed.

The RBHA is overseeing the transition process beginning May 1, 1999.

2. **Interim Management**

   a. **Administration of Current HUD Grants:**

   While ADHS has ultimate accountability, the RBHA will have oversight and responsibility for the current administration of the HUD housing grants. Initial focus will be to ensure a smooth transition from ComCare to the new Housing Administrator. ADHS/BHS housing grants have been transferred to the Housing Administration Agency effective May 1, 1999.

   b. **Transition Planning/Management to New Agency**

   The RBHA will oversee the transfer of the current HUD grants that have been administered by ComCare to the new Housing Administrator. Additionally, the RBHA will work with the Arizona Departments of Health Services and Commerce for grants that are administered from those agencies. The RBHA will assume the responsibility of completing the HUD renewal applications.

   c. **Contract Development and Monitoring**

   The RBHA will develop quality monitoring standards and protocols in association with the Housing Administrator. These reports will establish benchmarks to determine contract compliance.

   The RBHA will be the contract monitor of the Housing Administrator and will oversee the development of HUD contracts with housing providers and the housing administrator. Biweekly meetings will be held during the transition period (first 120 days) to ensure a smooth transition. After the transition period a minimum of monthly meetings with the Housing Administrator will be held.

   In addition to overseeing program compliance with housing providers, the RBHS will also interface with the clinical teams and the Housing Administrator periodically to ensure that appropriate housing and supportive services are being provided to consumers.

Monitoring tools and performance standards will be established by September 30, 1999. At a minimum the monitoring tools will include:

- Percentage & timeliness of accurate claims processed
- Number of consumers on wait list and length of wait period for housing
- Length of time needed to implement changes to supportive service plan and/or change of housing
- Maintenance of communication linkages established with providers, consumers, the RBHA and other stakeholders
- Collection and synthesis of HUD-required reporting elements
- Meeting Annual Performance Review and HUD contract standards

The RBHA will oversee this process and develop the necessary monitoring tools by September 30, 1999.

3. **Staffing Patterns and Analysis of Staffing Needs**

The RBHA, commits one FTE (Housing Manager) to:

- Serve as the contract manager with the nonprofit administrative agency,
- Provide strategic vision and community building in forging new partnerships to elicit (and pay for) new concepts in housing for the SMI population, and
- Ensure linkages among housing, vocational, clinical, and other service components.

This position is in the RBHA Service Integration Department.

In addition, the RBHA will ensure that each clinical team has a housing specialist available in order to provide assistance and consultation to the client and the clinical team regarding housing options.

The Nonprofit Housing Administrative Agency will provide a minimum of four positions to conduct the day-to-day business of managing the HUD grants. These will include an administrative assistant, two housing coordinators, and a housing operations manager. Additionally, the nonprofit will provide financial, technical, and other support services through their existing staff or through additional staff. When the nonprofit administrative agency takes on the responsibilities of housing development, it is anticipated that they will need specialized staff to assist in that endeavor.

ADHS/DBHS has established an IGA with the Arizona Department of Commerce (ADOC). The agreement establishes a formal relationship between the Departments of Health and Commerce. A staff position at the Department of Commerce is devoted to solely to serving the housing needs of the seriously mentally ill. This arrangement facilitates access to the housing opportunities that are not exclusively targeted for the disabled population and to a wide variety of other Commerce housing initiatives.

ADHS/BHS, ADOC and the RBHA have examined the staffing needs for the current administration and development of additional housing resources and have determined that the staff capacity and knowledge at ADHS/BHS, ADOC, the RBHA and the Nonprofit Housing Administrative Agency is sufficient at this time. During the development of the long term strategic plan it may be determined that additional staff resources are needed. Any additional increases will be fully explored at that time. However, resources are an issue with respect to finding providers who are willing to develop alternative housing resources. ADHS, ADOC and the RBHA are committed to making alternative housing attractive to housing providers.

Goal: Build linkages among housing, clinical, and other support needs so that persons are placed appropriately and supported to maintain their housing status.

1. Procedural Linkages

As an immediate plan, the RBHA will ensure that the clinical teams develop support plans to maintain people in housing once they are placed. This process began on May 1, 1999, and is meant to be an interim, teaching and "culture changing" strategy.

Once a consumer is identified as needing housing, and is determined to be SMI, the case manager (or PBHP in the future) refers the consumer to the Housing Administrator, which places the consumer's name on the appropriate housing wait list. The Housing Administrator is charged with initiating discussion with the consumer's case manager (PBHP) to discuss issues that might impact the person's housing. These issues might include whether or not clinically they should hold a lease in their

name, level of support required, whether they should live alone or with others, etc.

Once space becomes available, the consumer is put in contact with a housing provider, and the Housing Administrative Agency notifies the RBHA of the placement. This placement will be entered into the RBHA MHS system, in order to generate reports for service match, treatment services provided to SMI homeless persons, in housing and quality monitoring.

Concurrently, the RBHA notifies the case manager (PBHP) that housing has been found for the consumer, and requests the case manager (PBHP) to develop an individualized plan to support the consumer in their housing placement. The RBHA began tracking the development of the plans on May 1, 1999.

2. **Development of Protocols**

The RBHA will initiate, with the selected Administrative Agency, the development of communication, referral, problem resolution protocols, and linkage systems with the RBHA and providers regarding coordination of services and reporting procedures. These protocols will be developed with the input and participation of all key stakeholders, including clinical providers, consumers, the Tenant Advisory Council, the Housing Administrative Agency, landlords, housing providers, and the RBHA. The intent is to build a partnership among these stakeholders to develop the actual procedures and to build ownership of those processes so that they are actually implemented and work in the best interests of the consumers.

The RBHA is responsible for these activities which began on May 1, 1999 and will be completed by September 30, 1999.

3. **Community Housing and Employment Partnership (CHEP)**

The RBHA will be initiating and facilitating the Community Housing and Employment Partnership (CHEP) to bring together key stakeholders to consider current and future funding, service delivery, evaluation, and development of housing and employment opportunities for persons within the behavioral health system. Consumers, advocates, and family members will be key members of this group that will work to define priorities, research options and solutions from other states and projects, and develop support for ongoing work in Maricopa County.

The Service Integration Department of the RBHA's Service Center has convened this group.

4. **SMI Interagency Clinical Work Group**

The Seriously Mentally Ill (SMI) Interagency Work Group will be convened by the RBHA. This group will be composed of representatives from other systems of care that are involved with SMI clients, including:

clinical providers, the RBHA, RSA, Adult Protective Services, law enforcement, the crisis system, the judicial system, parole and probation, and housing. The group will incorporate providers and clinicians, as it works to identify and solve interagency barriers by focusing on improving care, one consumer at a time.

The RBHA will identify the members of the SMI Work Group and initiate this process in July 30, 1999.

5. **Internal RBHA Communications**

The RBHA Service Integration Department will develop operational procedures with the PBHP/Case Manager, clinical team housing specialist, team benefits specialists and Housing Administrator to ensure that consumers receive appropriate clinical support. Monthly meetings with the Housing Administrator and appropriate PBHP/Case Managers will be held. These meetings began in May 1999. Additionally, the Housing Manager will interface with the RBHA fiscal and quality staff to develop reporting procedures that track service dollar match, treatment services and to develop quality monitoring reports. This cross-functional approach to administration will ensure continuous feedback and allow improvements to the process as needed.

These activities will begin by July 1, 1999.

6. **Build Linkages with PATH and SAMSHA Grants**

The RBHA will develop protocols for accessing information needed for grants, and working to coordinate care and services across grants and the RBHA service delivery system. Specific procedures will be established whereby compliance with grants facilitates housing placement for consumers. These protocols will be submitted to ADHS/DBHS for their review and approval.

Goal: Develop community and political linkages and resources to develop and implement a long-term strategic plan to meet the housing needs of behavioral health consumers in Maricopa County.

The most critical factor needed in order to ensure a successful housing program is the development of a comprehensive and creative approach to this issue that includes our many partners. The RBHA, as the agency responsible for the administration of housing programs, must have the cooperation of other state agencies, including ADHS and Department of Commerce (ADOC), in the development of housing initiatives. A specific plan outlining roles and responsibilities of each entity will be developed and the RBHA will provide regular feedback to ADHS regarding this process. Specific strategies include:

1. **Educate Public Officials:**

The RBHA will work with ADHS and ADOC to educate County and City policy makers and HUD regarding the challenges in obtaining the

necessary resources to continue HUD funded homeless housing programs. Funding will be explained and assistance sought to obtain legislative relief of currently mandated five year Shelter + Care funding renewals. Support from the Directors of the ADHS and ADOC is currently underway and will continue through the duration of the plan.

The RBHA Service Integration Department will be responsible for these duties.

2. **Develop Working Relationships:**

Critical to the success of this effort is the development of cooperative, working relationships among many parties. Cooperation among funders, providers (both housing and treatment services), the Office of the Monitor, and the Housing Administrative Agency is needed. The foundation for strong working relationships will be the responsibility of ADHS/DBHS.

All of the responsible parties, including the newly selected housing administrator, will be convened and a comprehensive strategy will be developed that:

- Outlines alternative funding strategies;
- Delineates roles and responsibilities for each agency in administering and developing housing options; and
- Develops and monitors the action plans needed to increase housing opportunities.

This task is ongoing.

Goal: Develop a seamless continuum of housing options for consumers now and as the service delivery system evolves.

1. **Convene Panel to Clarify issues and Needs**

As the RBHA implements change in the service delivery system, there will be concurrent reactions in other parts of the system as well. Within the housing continuum, this may first emerge as persons in residential treatment (including semi-independent living) improve, and no longer meet clinical criteria for residential treatment. If the person does not have a home to be released to, and if the waiting lists for independent housing remain, this poses a treatment dilemma for which there are no easy answers.

The RBHA will convene a meeting in July 1999 that will include representatives from DBHS, Commerce, the RBHA, consumers, network staff, the case management agency, and other key stakeholders, to clarify and define the potential issues, and to develop strategies for addressing the identified issues.

2. Adjust Plans to Reflect System Changes

Developing action plans is not a one-time event. Because of the continuing evolution of the service delivery system, an ongoing work group will need to monitor system changes and their effects on the living situations of consumers. A standing work group with this task will be implemented following the work of the panel, and will be charged with anticipating the impact of system changes, monitoring those impacts, and convening appropriate task forces to develop strategies to address problems that emerge. This group will also be charged with ensuring that all clinical work flows throughout the system - at provider and Service Center Levels - incorporate action steps to support consumers in the most independent level of housing possible.

The RBHA will undertake this effort beginning August 1, 1999.

C. Objectives and Activities

1. Federal Housing Initiative – HUD

a. HUD

The chart found in Attachment I lists the current housing resources available through HUD funds. Initially these funds were obtained through an application process whereby ComCare applied directly to HUD in Washington, DC for funds. Funding for the Shelter + Care program was ideal funding mechanism for ComCare because for every dollar in services ComCare provided, HUD matched those funds dollar for dollar with housing dollars. ComCare was able to secure millions of dollars of Shelter + Care funds via this program.

However, Shelter + Care funds have only a five-year duration, and at the end of the grant period, application for renewal funds must occur. An additional complication to this renewal process, is that HUD has changed the rules for obtaining Shelter + Care funds, and now every agency that receives HUD Homeless Housing funds must apply for funds through a local Continuum of Care process whereby all service providers compete locally for funds. A citizen's review panel ("Continuum of Care") prioritizes the funding applications and makes recommendations to HUD for funding.

Current funding resources provide both project-based and tenant-based rental assistance, supportive services, and operation funds. All of the funding is for permanent housing for homeless, seriously mentally ill individuals.

During the year 2000, 414 units of Shelter + Care housing subsidy will expire. If those units were renewed for a full five-year period of time, the grant award would be more than $11 million. In 2001, an additional 325 units of housing that receive HUD Shelter + Care subsidy will expire. Their full renewal value is approximately $10

million. An additional $9.5 million is needed to continue the StarGate program including the Safe Haven, UMOM, and Brookside programs which will also expire during this same two time period. Under the current HUD rules, all Shelter + Care renewals must be for five years. The other programs cited in this paragraph reflect three-year funding requests, the maximum that can be requested. However, these programs can be renewed for a minimum of one year. Both the StarGate and Safe Haven programs were renewed last year for a period of one year. During last year's Continuum of Care renewal process members of the review committee expressed strong reservations about renewing these projects based on the media attention that was focused on ComCare's financial status. In order to retain these units, ADHS/BHS stepped in and assumed grantee status for the projects for a one year period. This optional shorter-term renewal greatly reduces the cost (by one-third) but it does require that these projects must compete on an annual basis with other renewals.

Since HUD has changed the application process to the local, citizen-based review process, Maricopa County has received an average of $8 million per year in funding over the past two years. One Shelter + Care program alone (which expires in 2000, and thus must be included in the next Continuum of Care application) is over $9 million in cost.

b. Section 8

Section 8 is a program administered by HUD, but funded with resources other than the Shelter + Care program, that provides rental assistance to low income and homeless individuals. Rents are calculated so that the tenant pays 30 percent of income and HUD provides the balance of the rental payment so long as it does not exceed Fair Market Rents (FMRs) developed by HUD. As a part of every intake process for consumers obtaining HUD housing, the RBHA and the case management agency will ensure that each consumer's name is added to Section 8 wait list. The list is very long, but many consumers have transferred their Shelter + Care housing assistance to Section 8 funding thereby obtaining permanent rental housing assistance from a source other than HUD Homeless housing funds, and provides permanent subsidy which does not expire every five years. The Department of Commerce, HUD and ComCare have estimated that over 1000 seriously mentally ill class members have obtained Section 8 housing through this process. Obtaining an exact number of individuals who are receiving Section 8 housing has been difficult due to the confidentiality requirements for both Section 8 and mental health services.

Additionally, ADHS and ADOC recently assisted the City of Mesa for a successful application for 100 Section 8 certificates. It is estimated that 80 percent of these certificates were used to house RBHA members. This approach was replicated with the City of Phoenix for an additional 120 Section 8 certificates. This program can be expanded to other communities in Maricopa County. It is anticipated that HUD will be providing additional Section 8 certificates for special needs populations, including the RBHA's enrolled consumers. It is proposed that the RBHA, ADHS and ADOC take the lead in working with Housing Authorities to expand this program, and the RBHA will assist as necessary. The RBHA will continue to provide necessary treatment services to clients regardless of the source of funds that pays for housing assistance.

The Housing Manager, Case Managers and the Housing Administrator will carry out this function.

c. HUD Continuum of Care

Competition for funding this year will be great. In addition to the Shelter + Care programs 414 units needing renewal funding, the StarGate and Safe Haven programs need renewal funding. The RBHA is working with ADHS and ADOC to obtain support from local government entities to support a change in HUD statute for a shorter renewal period. Currently, HUD requires that these programs be renewed for five years. If the renewal period could be shorter, the chances of receiving funding in 2000 is increased, since we would be

seeking one or two years of funds, rather than five. This reduces the dollar amount from $11 million to $2.2 Million (one year) or $ 4.4 Million (two years).

This effort is currently underway and being staffed by ADHS, ADOC and the RBHA.

d. Renewal of HUD funding:

Preservation of existing housing resources is the number one priority for ADHS/BHS, DOC, and the RBHA. Four hundred and fourteen (414) Shelter + Care certificates expire during the year 2000. Additionally, Nova Safe Haven and StarGate programs last year received a one-year renewal, so they will need to be included in the renewal process. Operational support for 19 permanent, supportive housing units are ending also. The cost for renewals of all of these programs (fully funded according to HUD guidelines) is nearly $19 million. It should also be noted that next year, an additional $11 million in renewal projects (339 Rental Assistance Units and operating subsidy for 10 units) will also need renewal funding. During the last two years, the City of Phoenix, City of Mesa and Maricopa County combined award was $8 million each year.

To address this funding challenge, a coordinated strategy will be developed that includes the major stakeholders including: ADHS, ADOC, local cities, HUD, units of local government, the Court Monitor, the RBHA, and private entities. The Housing Manager will convene a meeting of these entities to develop strategies to address the preservation of the housing units. Each entity will have roles and responsibilities for the implementation of the plan. The Housing Manager will monitor this process and make monthly progress reports to ADHS. It is anticipated that the first meeting of this working group will be in July1999.

It is anticipated that the strategies will include:

- Working with ADOC to obtain an administrative technical correction of the current HUD regulations that require five year funding renewals for Shelter + Care certificates to obtain a lesser time renewal period, so costs can be reduced;
- Selecting housing developer(s) to begin developing or securing housing stock;
- Securing local and state funding to address on-going housing costs.

ADHS/DBHS and the RBHA will be closely involved during the HUD Continuum of Care planning process. The Continuum of Care staff will be informed of the progress of the working group and seek input from staff to assist in the process. Input from the RBHA CHEP

will also be sought to develop support for the development of a renewal strategy.

2. **State Housing Initiatives – ADOC**

   a. **ADOC Budget Request**

   In conjunction with ADHS, ADOC submitted a funding request to provide two years of Shelter + Care funds. This request is needed to ensure that currently housed persons will not become homeless because they no longer have rental subsidy and also to provide time to develop additional funding strategies. This item was not included on the final Governor's funding recommendations. The RBHA will assist ADOC and ADHS in educating public officials of the need for this funding. ADHS will continue to request this funding whenever budget proposals are sent forward.

3. **ADHS Initiatives**

ADHS, in conjunction with the RBHA, will assume primary responsibility for developing, coordinating, and implementing the HUD and ADOC initiatives. To the extent that the federal and state housing initiatives are not reasonably likely to succeed in preserving all of the HUD housing units scheduled for termination in FY 2000-2001, ADHS will, through a supplemental budget request for FY 2001 make its best efforts to obtain funding to ensure that at least the same number of housing units are available to class members as existed January 1, 1999. As described in ¶20 of the Supplemental Agreement, ADHS is responsible to request the funding necessary to replace these housing units, as well as develop additional units as provided for in the service development attachment.

   a. **In-Home Supports and Wrap-Around Services**

   ADHS/BHS is responsible for the development and provision of the full array of in-home supports and wrap-around services for class members in need. These supports can range from intensive, around the clock support to minimal supports provided only when found to be necessary. During the development of each class members Individual Service Plan, the clinical team in conjunction with the client, is responsible to plan for and ensure the provision of adequate services so that the client can achieve and maintain their independence in their own community living arrangement.

   The services and supports should be tailored to meet the person's individual needs and will be available to the client regardless of where they live.

   It is well known that historically the service system has not had the capacity or the flexibility to respond to the changing needs of class

members in a timely manner. Consequently, many clients have been at risk of or have literally lost their housing due to the lack of appropriate in-home services.

Consumers have expressed needs for additional recreational activities, vocational activities and social activities in order to have something meaningful to do, as well as to prevent the social isolation that typically plagues them. Also, they have expressed the specific need for increased involvement from case management in the transitioning process from inpatient treatment to living in the community. Consumers have also expressed a strong need for education and information regarding housing, the Arizona Residential Landlord Tenant Act, leases, the RBHA and the roles and responsibilities of the housing providers. Also, consumers have requested assistance with the start-up costs associated with establishing a new living arrangement.

The long-term strategic plan discussed later in this document will address this area in a comprehensive fashion. This will include service development projections as determined in the service development attachment, including specific services and targets for implementation. The long-term plan will also focus heavily on the types of services and the strong need for the system to be flexible and responsive to class members.

b. State Dollars Targeted for ASH Transition

State funds are allocated for consumers who leave ASH or in Maricopa County from Supervisory Care Homes and move into HUD subsidized housing. ADHS/BHS is currently budgeted for $7.8 million dollars to fund statewide community placements for patients that are ready for discharge from the Arizona State Hospital. Expenditure of these funds is currently controlled by a formula that is driven by the ASH census with each RBHA having a census target. Maricopa County receives the majority of these funds. Additional funding will be needed in order to continue to move forward with the development of community living arrangements for ASH and Supervisory Care Home placements. The Service Integration Department and the Housing Manager are an integral part of the planning process for the development of additional community living arrangements.

4. The RBHA Initiatives

In addition to assisting with the above initiatives, the RBHA will develop a tracking system, which identifies all class members who are at risk of losing their housing. This tracking system should include what actions must be taken to ensure that the client does not become homeless. The

clinical team will be responsible for developing and implementing individual housing plans for all class members in order to insure that the necessary actions to prevent homelessness are clearly described, implemented and monitored.

During the development of the long-term plan, the RBHA will describe in detail its plans for adding the appropriate level of housing expertise to each clinical team so that the housing and support needs of class members can be addressed during the development of the ISP. Additionally, the RBHA will develop methods to track class members residing in any form of subsidized housing. This information should also include the number of class members needing housing and the dates of the referral.

V. LONG TERM PLAN

By March 15, 2000, ADHS will finalize a long-term strategic housing plan that describes specific goals, objectives, activities, processes, and outcomes for creating a sufficient array of housing options to meet the needs of class members. The plan will be deemed as an amendment to this plan.

The long term plan will set forth the strategies and actions that will be intended to address the unmet housing needs of class members and provide a permanent foundation and capacity for the provision of an adequate array of housing options. The plan will specify the number, type and costs of housing alternatives, which are determined to be needed by class members. Additionally, it will identify objective outcomes to allow an assessment of whether the specific strategies and actions are successful in achieving the goals of the plan. The plan will include, at a minimum, the following elements:

A. Need

1. Service Development Plan

The parties will complete a service development attachment plan by July 1, 1999 that will identify the amount, level, and type of various residential services and different types of housing with supports needed by class members. This service development attachment will serve as the document, which sets forth the housing needs of class members. All planning, funding and implementation of housing options will be based on this plan. The long-term strategic housing plan will be based on the information contained in the service development plan. The long-term plan will define the process by which class member's housing needs are prioritized and "eligibility" for subsidized housing is determined.

B. **Federal Housing Initiatives**

1. Low Income Housing Tax Credits (LIHTC)
2. Tax Exempt Bonds
3. ADHS/ADOC/ADES Joint Venture – Supportive Housing Demonstration Program
4. Section 811
5. Conversion of Tenant-Based to Project-Based Section 8 Vouchers
6. Long-term operating subsidies
7. All other federal housing initiatives

C. **State Housing Initiatives – ADOC**

D. **ADHS Initiatives**

1. In-Home Supports/Wrap-Around Services and Start-Up Costs
2. Definitions and Eligibility Criteria
3. Research
4. Best Practices
5. Other Models; i.e. Fountain House, Anishinabe Wakiagun, etc.

D. **Implementation and Monitoring**

This should include Goals, Objectives and Strategies for implementation including updated timelines. This section will also include detailed plans that will outline the responsibilities of each party as well as the tracking mechanisms to ensure tasks are completed and monitored.

VI. LIST OF ACTIVIIES, PLANS AND TIMELINES

Initial time lines and accountabilities for activities described in this plan are outlined here. As detailed in the plan, however, many of these will be expanded by the participation of broader groups of stakeholders. The first chart indicates activities currently underway, followed by future tasks.

Task	Responsible Party	Date	Others Involved
Administration of Current HUD Grants	RBHA	Ongoing	ComCare staff Housing and Service Providers
Organize CHEP	RBHA	Ongoing	City of Phoenix Staff City of Mesa Staff HUD/ADOC/ADHS Maricopa County Staff Community Representatives
Educate Public	ADHS	Ongoing	ADOC/HUD

Officials	RBHA		City of Phoenix and Mesa/Maricopa County Staff
Increase the number of Section 8 certificates	ADHS RBHA	Ongoing	ADOC will take the lead in this effort. The will support effort as needed
Support ADOC Budget Request	ADHS RBHA	Ongoing	ADOC will take the lead in this effort. The RBHA will support effort as needed
Participate in the HUD Continuum of Care process	ADHS RBHA	Ongoing	ADOC/HUD Housing and Service Providers
Investigate using Tax Exempt Bonds for financing housing	ADHS RBHA	Ongoing	ADOC
Develop strategies for renewal of HUD housing units	ADHS RBHA	Ongoing	ADOC/HUD
Organize HUD renewal providers meeting	ADHS RBHA	Ongoing	Housing and Service Providers ADOC Housing Administrator

The following activities indicate future housing activities.

Task	Responsible Party	Date	Others Involved
Develop PATH and SAMSHA interface	ADHS RBHA	Ongoing	Grant Administrators Housing Administrator
Begin transition plan for Housing Administrator	RBHA	5/1/99	Housing Administrator ComCare staff
Develop fiscal reporting systems	RBHA	9/30/99	RBHA fiscal staff Housing Administrator

Convene SMI Work Group	RBHA	Complete	Clinical Providers, RSA, Adult Protective Services, Law Enforcement, Crisis System, Judicial System, Parole, Probation
Monitoring tools & performance standards for Housing Administrator established	RBHA	9/30/99	ADHS/ADOC HUD
Write Renewal Applications	RBHA	Complete	ADHS/ADOC/HUD Housing Administrator
Develop Plan for filling housing gaps	ADHS RBHA	Long Term Plan	RBHA Service Integration Team ADOC/HUD Housing Administrator
Begin research on best practices & other models	ADHS RBHA	Ongoing	ADHS/ADOC HUD
Research, best practices and other models info. Dissemination	ADHS RBHA	Long Term Plan	ADOC/ADHS HUD
Recruit nonprofit to obtain tax exempt bond $ and provide technical assistance	ADHS RBHA	Long Term Plan	ADOC
Support ADHS/ADOC/ADES joint venture	RBHA	Long Term Plan	ADOC/ADHS ADES
Recruit nonprofit to apply for LIHTC $ and provide technical assistance	ADHS RBHA	Long Term Plan	ADOC Housing Administrator
Assist in efforts to convert tenant base to project based Section 8 vouchers	ADHS RBHA	Long Term Plan	ADOC will take the lead in this effort.
Support Specialized Section 8 funding	ADHS RBHA	On-going	ADOC will take the lead in this effort. The RBHA will support effort as needed

Support ADOC Budget Request	ADHS RBHA	On-going	ADOC will take the lead in this effort. The RBHA will support effort as needed
Support nonprofits to apply for Section 811	ADHS RBHA	On-going	ADOC
Finalize and submit Long Term Strategic Housing Plan	ADHS	3/15/2000	ADOC RBHA

VI. APPENDICES

Attachment I - Current HUD Funded Programs

Attachment II - HUD Housing Flow Charts Draft – December 30, 1998

Superior Court of Arizona
Arnold, et al v. Sarn et al
C-432355

Office of the Monitor

Bernard J. Dougherty
Assigned Judge

Linda L. Glenn
Monitor

Ralph E. Hughes
Executive Director

April 3, 1996

The Honorable Bernard J. Dougherty
Superior Court of Maricopa County
201 West Jefferson, Suite 8-B
Phoenix, Arizona 85003

Dear Judge Dougherty:

In accordance with Paragraph 15 of your February 12, 1996 Order approving the Joint Stipulation on Exit Criteria and Disengagement, I am submitting the report on "Priority Supervisory Care Homes" as required of my office. This list requires Court approval.

As can be seen from the report, the Office of the Monitor reviewed 48 facilities on a standard protocol that allowed for a ranking of each facility.

As a result of this review, several actions, in addition to the obligations of this office under the Stipulation, will be undertaken.

1. Situations and inadequate conditions of care were found in several facilities that required immediate attention to protect class members. Licensing, DBHS, and ComCare responded immediately to these four incidents. All follow-up actions planned should continue. This office will follow up with ADHS.

2. Five of the facilities in the review were given to this office as Supervisory Care facilities but were found to be unlicensed. While Section (IV), Paragraphs 13-14, addresses both Supervisory Care and Board and Care Homes, Paragraph 15, which governs the designation of priority homes by my office, is specific to Supervisory Care. For this reason, the designated "Priority Homes" in the attached report only include those licensed by ADHS as Supervisory Care. Our review of the unlicensed facilities, however, found several substantially below minimally acceptable. We will provide this list separately to ADHS and ComCare. It is the recommendation of this office that the fourteen (14) ComCare members who live in four of these homes be provided alternative living arrangements.

3. ADHS and County defendants, under Paragraph 17, cannot transfer, or recommend for transfer, any class member to a Supervisory Care Home except in a unique situation. ComCare currently has a process for central review of any case manager's or clinical team's decision to admit to a Supervisory Care Home. While this process may be adequate, it is the

Phone (602) 220-0276
2509 E. Fillmore St. Phoenix, AZ 85008
Fax (602) 220-0278

recommendation of the Monitor's office that, if this eventually does occur for any one class member, that only certain Supervisory Care Homes be allowed to be used. The Monitor's office review prioritized eighteen (18) homes for development of appropriate alternate living arrangements for the residents to meet their obligation under Paragraph 15. Another eight homes received below zero (0) in the scoring system. These homes (list to be provided to ADHS and ComCare) should not be used in any situation for class member placement. In addition, a process will have to be established for the Monitor's office review of any home that is considered for use that has not been a part of this review.

4. The Monitor's office review encountered many situations, even in facilities that did not become "prioritized" homes, that raised questions in regard to licensing and oversight of these homes (e.g., medication management issues, residents providing staff coverage, etc.). It is the intent of this office to meet with ADHS to discuss current and future licensing practices and possible changes in the ADHS licensing regulations governing these homes. In addition, the problems uncovered in unlicensed facilities need to be addressed by ADHS.

5. Part of the review of whether the Supervisory Care facilities were appropriate for the individual class members in residence was a review of any existing ISPs and interviews with the case managers serving clients in each home reviewed. While the purpose and scope of the review was not intended to be an assessment of ComCare, several issues emerged (e.g., case managers not fully understanding the ADHS Administrative rules on ISPs, class members not assigned to case managers, etc.). As a result of these findings, the Office of the Monitor will meet with ADHS and ComCare to share information that may assist in ensuring compliance to other aspects of the Exit Criteria.

If you have any questions in regard to this report, please let me know.

Sincerely,

Linda L. Glenn
Court Appointed Monitor

LLG/sgl

Attachment

cc: Anne C. Ronan
Steven Schwartz
Cathy Costanzo
Amy Leeson
Eva Bacal
Theresa Dwyer
Andrew M. Federhar
Louis Gorman
Gary Birnbaum
Charles L. Arnold
Jim Griffith
Pamela S. Hyde
Rhonda Baldwin
Linda Mushkatel

ref: d:\sgl\docs\sprvsyca\jdgltr.doc

Office of the Monitor

Arnold v. Sarn

Supervisory Care Homes in Maricopa County: Identification of Priority Homes Serving Class Members April 3, 1996

Prepared for:

The Honorable Bernard J. Dougherty
Superior Court of Maricopa County
In Fulfillment of Requirements (¶15)
of the Stipulation on Exit Criteria and Disengagement
(February 12, 1996)

I. INTRODUCTION

The Joint Stipulation on Exit Criteria and Disengagement, signed by the Court on February 12, 1996, requires that "ADHS will provide two hundred ... community living arrangements and appropriate supports to class members who reside in supervisory care homes, which the Monitor will identify within ninety days of the execution of this Stipulation, and which are approved by the Court as priority homes."(¶15)

This report, which has been completed to fulfill the Monitor's obligation of the above referenced court requirement, is divided into four sections. These sections describe: a) the process and criterion used by this office to develop an audit procedure to determined the list of priority homes; b) how this office obtained the list of homes that were actually reviewed; c) the difficulty uncovered in reconciling the number of class members in each of the facilities reviewed: and d) the list of designated priority homes.

A. Process

The Office of the Monitor identified a team of seven auditors to perform the supervisory care home review between January 23 and March 19, 1996. The auditors are qualified professionals in the field of mental health who are experienced in evaluating or providing services to persons who have a mental illness. Each auditor was trained specifically on the requirements of *Arnold v. Sarn*, on paragraph 15 of the Stipulation and on the implications of service delivery to the class members in Maricopa County. The training prepared each auditor to complete a protocol booklet for each facility reviewed.

The audit protocol is a series of working papers that was developed to objectively identify Supervisory Care facilities within Maricopa County that are not providing the quality of care to which persons with a serious mental illness are entitled. These entitlements come from the rights and services created by both the Arizona Legislature (through statutes) and the Department of Health Services (through its rules), and reinforced by agreements reached as a result of the *Arnold v. Sarn* lawsuit.

The priority homes have been identified through the application of this protocol and through an analysis of the data that was gathered. This data was a compilation of standards and criteria, drawn from the above statutory and regulatory sources which answer the following questions:

- Does the facility provide for the basic rights of the person?
- Does the facility ensure the health and safety of the person?
- Does the facility provide a humane environment and an appropriate quality of life?
- Does the facility meet the needs of the individual?

Each audit team (usually consisting of two auditors) conducted a series of separate interviews at each facility, with the manager on site, with various staff, with anywhere

from one to three class members residing at the facility (depending on the size), and with the ComCare case managers that were assigned to each of the members interviewed. The team also conducted a series of structured observations that included observations of a meal, of a medication administration session, of residents' activities, of general personal care, and of the entire facility's environment. All records that were kept by the facility on the individual class members interviewed were reviewed by auditors, as well as all existing policies and procedures (e.g., admission/discharge policies, medication policies, rules of the facility and rights of the residents). Each team reviewed the ComCare plan that was currently in effect for the particular ComCare class members that were interviewed (whether that was an ISP or an EISP). Finally, the audit team members reconciled ratings of facilities between team members and met to discuss, with the Monitor, general findings, ratings and recommendations of the team that involved adequacy of the planning and service delivery to the individuals sampled.

Ratings that were reached by auditors in summarizing their assessment of each of the facilities, were obtained by analyzing a series of questions that were developed from the standards and criteria referenced above. These ratings will be displayed in this report for those facilities determined to be priority homes under paragraph 15 of the Stipulation. Neither the actual data, nor the narrative justifications written as a result of this review, is provided in this report. This data will be retained within the Monitor's office.

B. Homes Reviewed

The Office of the Monitor requested from the Arizona Department of Health Services, a list of all of the ComCare members who were residing at a supervisory care home within Maricopa County, along with the name of the facility and the name of the case manager assigned to each of the members. Through ComCare, such a list was produced by ADHS, with ComCare members known to be in residence as of February 8, 1996.

The ComCare list contained 42 homes. During our review, it was found that 37 of these homes were licensed by the ADHS as "Supervisory Care Homes" within Maricopa County. The review also covered five homes that were not licensed. Additionally, the Office of the Monitor visited six more homes that were not on the original list. The names of these homes were obtained by: a) making phone calls to the Supervisory Care facilities on the licensing list that were not included on the ComCare list, and inquiring whether they had ComCare members/residents; b) through discovery during the course of the audit or; c) through subsequent communications with DBHS staff. These additional facilities were then reviewed. A total of 43 supervisory care homes and five (5) unlicensed board and care homes were reviewed in this audit.

C. Difficulties With Validating the Census Within Individual Facilities

There were two problems that should be mentioned in this report that occurred throughout the course of the audit. The first was trying to determine the actual number of class members within each of the facilities reviewed. During the scheduling process that occurred prior to each of the audit teams' visits, the list of facilities/members from ComCare was utilized. Contact was made with case managers prior to the teams' visit in order to make them aware of

the review and to obtain the ISP/EISP of the particular members the teams were hoping to interview. A substantial amount of inaccuracies were found within this list. Often ComCare members identified for an interview no longer resided at the facility (sometimes for several months). Additionally, ComCare class members were found residing in facilities who were not on the list provided to this office by ComCare/ADHS.

The second problem was that auditors encountered some Supervisory Care Home managers who reported having residents within their facility who had a serious mental illness, who had applied for ComCare services and who had been denied. It has been assumed for purposes of this review a person is a class members in *Arnold* if they are seriously mentally ill and a member of ComCare. This issue will need further exploration at a future date.

Each of the audit teams, in most of the facilities visited, requested that the manager provide a list of all of the ComCare members that resided within their facility. This list also often differed from the list provided by ComCare/ADHS. This information will be shared with the appropriate ADHS and ComCare personnel.

II. PRIORITY HOMES

Each of the audit teams determined a final rating for each of the facilities reviewed by answering (and justifying) a series of questions that were answered with either a plus one (+1 - indicating a positive finding), a zero (0 - indicating a less than positive finding, but one that indicates partial satisfaction) or a negative one (-1 - indicating a finding of non-compliance). There were a total of 24 questions. Each facility, therefore, had the ability to achieve a score that ranged anywhere from a positive (+)24 to a negative (-)24. Attachment A is the list of licensed Supervisory Care Homes determined by the audit team as the facilities that need to be prioritized by ADHS and ComCare in satisfying paragraph 15 of the Stipulation. Accompanying each named facility is the score for that facility and the number of ComCare members (known class members)that this office believes to be in residence.

ATTACHMENT A - PRIORITY HOMES

Supervisory Care Homes by Ranking

Home	Score	Address	Total Clients	# Class Members[1]	Cumulative Class Members
Sunny Acres	-23	215 West Sunland Avenue Phoenix, AZ 85041	9	6	6
Desert Fountain	-22	6420 South 22nd Street Phoenix, AZ 85040	42	12	18
Sunshine One Supervisory Care Home	-21	801 West Roosevelt Phoenix, AZ 85007	18	10	28
A-1 Guest Lodge	-20	6632 South 22nd Street Phoenix, AZ 85040	44	39	67
Lodges West	-20	5251 South Third Street Phoenix, AZ 85040	27	27	94
Brookside	-17	5630 South 9th Street Phoenix, AZ 85040	59	21	115
Oakridge Professional Resident Care	-17	801 South 17th Avenue Phoenix, AZ 85007	38	6	121
Oakridge North	-16	1602 West McDowell Road Phoenix, Az 85007	19	4	125
Oakridge West	-15	716 South 17th Avenue Phoenix, AZ 85007	30	10	135

[1] Number of clients who are class members was derived from varying ComCare/DHS information and corrected if change was needed after evaluation of home.

Home	Score	Address	Total Clients	# Class Members[1]	Cumulative Class Members
Paradise Valley Home	-15	2802 East Juniper Avenue Phoenix, AZ 885032	32	26	161
Rainbow Valley Boarding Home	-15	13000 South Airport Road Buckeye, AZ 85326	10	10	171
Spring Garden Residential Care Home	-14	6016 West Glenn Drive Glendale, AZ 85301	32	6	177
Palatrones Guest Ranch	-13	3806 South 9th Street Phoenix, AZ 85040	13	11	188
Jackson & Son Dormitory, Inc.	-11	1614 East Wood Street Phoenix, AZ 85040	11	5	193
Family Home and Health Care	-10	5411 South Montezuma Phoenix, AZ 85041	31	27	220
Palmdale Supervisory Care Home	-10	3235 East Randolph Road Phoenix, AZ 85008	12	12	232
Pierce Supervisory Care	-10	6019 North 51st Avenue Glendale, AZ 85301	23	21	253
Crystal Lodge	-9	2941 North 14th Street Phoenix, AZ 85014	47	11	264

[1] Number of clients who are class members was derived from varying ComCare/DHS information and corrected if change was needed after evaluation of home.

Steven M. Friedman - State Bar #001879
Lisa Kurtz - State Bar #014515
BEGAM, LEWIS, MARKS & WOLFE, P. A.
111 West Monroe Street, Suite 1400
Phoenix, Arizona 85003-1787
(602) 254-6071

Attorneys only for Plaintiff, DENISE ACKERMAN, as Personal Representative of the Estate of Marilyn Joann Ulrich Brower, Deceased, for and on behalf of the Estate of Marilyn Joann Ulrich Brower, Deceased, and for and on behalf of the Statutory Claimants, Theodore Joseph Brower, Dawn Marie Alexander, Michelle Ann Carter and Valerie Theresa Alfonso, her surviving children, and Helen Neimas, her surviving mother

and

Randy J. Hurwitz - State Bar #016219
ANDERSON, HURWITZ & HARWARD, P.C.
6330 East-Thomas Road, Suite 320
Scottsdale, Arizona 85251-7057
(602) 874-2918

Attorneys for only Plaintiff, EDWARD GAUDREAU, as Personal Representative of the Estate of Matthew J. Brower, Deceased for and on behalf of the Estate of Matthew J. Brower, Deceased

SUPERIOR COURT OF ARIZONA

MARICOPA COUNTY

CV99-05407

DENISE ACKERMAN, as Personal Representative of the Estate of MARILYN JOANN ULRICH BROWER, deceased for and on behalf of the Estate of MARILYN JOANN ULRICH BROWER, deceased and for and on behalf of Theodore Joseph Brower, Dawn Marie Alexander, Michelle Ann Carter, and Valerie Theresa Alfonso, surviving children, and Helen Neimas, surviving parent of MARILYN JOANN ULRICH BROWER, deceased, Statutory Claimants; Estate of Marilyn Joann Ulrich Brower by and through its Personal representative, DENISE ACKERMAN; EDWARD GAUDREAU, Personal Representative of the Estate of Matthew J. Brower, Deceased, for and on behalf of the of Matthew J. Brower, deceased,

COMPLAINT
(Tort - Non Motor Vehicle)

Plaintiffs,

vs.

STATE OF ARIZONA; COMCARE, INC., an Arizona corporation; META SERVICES, INC., an Arizona corporation; K MART CORPORATION, a foreign corporation; BLACK CORPORATIONS I through XX; JOHN AND JANE DOES I through XX; ABC PARTNERSHIPS; XYZ BUSINESS ENTITY;

Defendants.

Plaintiffs, for their claims against Defendants, allege as follows:

COUNT ONE

NEGLIGENCE OF SATE OF ARIZONA, COMCARE AND META

I.

Denise Ackerman is the duly appointed personal representative of the Estate of Marilyn Joann Ulrich Brower, Deceased, (hereinafter "Marilyn Brower") who brings this action for and on behalf of the Estate of Marilyn Brower, Deceased, and for and on behalf of the Statutory Claimants for wrongful death damages arising out of the death of Marilyn Brower; Theodore Joseph Brower, Dawn Marie Alexander, Michelle Ann Carter and Valerie Theresa Alfonso, Marilyn Brower's surviving children, and Helen Neimas, Marilyn Brower's surviving mother.

II.

Edward Gaudreau is the duly appointed Personal Representative of the Estate of Matthew J. Brower, Deceased, and brings this claim on behalf of the Estate of Matthew J. Brower, Deceased.

III.

Defendant, the State of Arizona, acted through its agents, employees and servants who at all times material hereto were acting within the course and scope of their agency, employment and service for the Defendant State of Arizona, the Defendant State of Arizona caused acts to occur in the State of Arizona out of which these claims arise.

IV.

Defendant COMCARE, Inc., (hereinafter "Comcare") is and was at all times material hereto a corporation incorporated under and pursuant to the laws of the State of Arizona and at all times material hereto did business in the State of Arizona and acted through its employees, agents and servants who were at all times material hereto within the course and scope of their employment, agency and service and caused an act to incur within the State of Arizona out of which these claims arise. Defendant COMCARE was, at all times material hereto, acting as an agent of the Defendant State of Arizona, pursuant to a contractual arrangement with the Defendant State of Arizona to which Matthew J. Brower and Marilyn Brower were third party beneficiaries.

V.

Defendant K Mart, Inc., (hereinafter "K Mart") is and was at all times material hereto a foreign corporation authorized to do and doing business under and pursuant to the laws of the State of Arizona and at all times material hereto did business in the State of Arizona and acted through its employees, agents and servants who were at all times material hereto within the course

and scope of their employment, agency and service and caused an act to incur within the State of Arizona out of which these claims arise.

VI.

Defendant META Services, Inc., (hereinafter "META") is and was at all times material hereto a corporation incorporated under and pursuant to the laws of the State of Arizona, does and did business in the State of Arizona, acted through its employees, agents and servants who were at all times material hereto acted as employees, agents and servants of the Defendant META Services, Inc., and were within the course and scope of their employment, agency and service for Defendant META, and the Defendant META caused an act to incur within the State of Arizona out of which these claims arise. Defendant META was, at all times material hereto, acting as an agent of the Defendant State of Arizona, pursuant to a contractual arrangement with the Defendant State of Arizona to which Matthew J. Brower and Marilyn Brower were third party beneficiaries.

VII.

Defendants BLACK CORPORATIONS I through XX are corporations, partnerships, business entities, persons, agents, servants or employees whose true names are not presently known to plaintiffs. Plaintiffs are informed and believe, and upon such information and belief allege, that Black Corporations I through XX are corporations licensed to do and doing business in the State of Arizona which caused acts to occur in the State of Arizona out of which these claims arise. When the true names of such

corporations, partnerships, business entities, persons, agents, servants, or employees become known to plaintiffs, then plaintiffs will request leave of the Court to amend this complaint to reflect such true names together with appropriate charging allegations.

VIII.

Defendant DOES I THROUGH XX are particularly denominated as follows:

A. Does I through X are the administrators, agents servants, employees, directors and/or managers of the defendants State of Arizona, and/or META.

B. Does XXI through XXX are persons, agents, servants, employees, administrators, directors and/or managers of the defendant COMCARE.

C. Does XV through XX are persons, agents, servants, employees, administrators, managers and/or directors who had any part in the care and treatment of Matthew Brower, Deceased, in or about the period beginning at approximately January 14, 1998 until and including March 31, 1998.

IX.

On or about March 31, 1998 Decedent, Matthew Brower, shot and killed Decedent, Marilyn Brower, who was his natural mother, and then shot and killed himself.

X.

The death of Marilyn Brower and the death of Matthew Brower were both as direct and proximate result of the carelessness, recklessness, and negligence of the Defendants.

XI.

Defendant State of Arizona acting through its agents, servants and employees, including the corporate defendants named in this Complaint, had a legal duty to provide mental health services to the citizens of the State of Arizona in general, to Matthew Brower in particular, and assumed and undertook to render mental health care to Decedent, Matthew Brower. In doing so, Defendant did so carelessly, recklessly, and negligently resulting in the death of Marilyn Brower and Matthew Brower.

XII.

Decedent Marilyn Joann Ulrich Brower died sometime in the morning of March 31, 1998 at her home at 8130 North 42nd Lane, Phoenix, in Maricopa County, Arizona, as the result of a gunshot wound to the head inflicted upon her by her son Matthew J. Brower. After shooting Mrs. Brower, Matthew J. Brower turned the gun upon himself and inflicted a fatal gunshot wound to his own head.

XIII.

At the time of the shootings, Matthew J. Brower was 28 years of age, a diagnosed schizophrenic with a history of self-mutilation, suicidal ideation, anger, hostility, violence and increasing threats of violence to others. With the exception of a brief period in December 1997 and January 1998, he had been involuntarily and continuously committed for mental health treatment and care under the administration and treatment of Defendant COMCARE since September 1996. Specifically, on September 24, 1996, the Superior Court of Arizona, Maricopa County, determined, based upon behavior which included a gunshot

wound to his genitals, severance of his penis, suicidal threats and other violent conduct, that Matthew Brower was in need of involuntary commitment for treatment, in that he suffered from a mental disorder and was a danger to himself and to others. The Superior Court's order directed that Matthew be subject to involuntary treatment, administered by COMCARE, for a period of up to six months. In January 1997, the Superior Court renewed its involuntary commitment order.

XIV.

On or about January 16, 1998, decedent Marilyn Joann Ulrich Brower made application for emergency mental health evaluation of her son by psychiatrists at the Maricopa Medical Center's Psychiatric Annex. Her petition asserted that Matthew had been "verbally aggressive" to her, was unable to provide even basic physical care for himself, made "outbursts and statements that did not pertain to anything at all", and was in danger of setting the house afire. Upon examination, Center psychiatrists ascertained that Matthew had not taken his medications for three weeks, admitted that he "raised [his] voice" to his mother, and felt that he was ill and needed hospitalization. The examiners found Matthew to be acutely disabled and possibly psychotic, verbally hostile and threatening to his mother, a danger to himself and others. On January 29, 1998, Maricopa County Superior Court Commissioner Robert A. Colosi ordered Matthew Brower to receive inpatient treatment at a local mental health agency for at least twenty-five (25) days and outpatient treatment to be administered by Defendant ComCare and the Arizona Department of

Health Services, a subdivision of the Defendant State of Arizona, for a period of up to six (6) months.

XV.

In the ensuing weeks, Defendants' agents, servants and employees concluded that Matthew Brower was danger to himself and others, was persistently and acutely disabled and that it was reasonable to foresee that Matthew would cause serious physical harm to himself and others unless he was given appropriate treatment and appropriately restrained.

XVI.

On or about January 29, 1998, Matthew Brower was, by virtue of his continuing deteriorating mental health condition, committed by the Superior Court of Maricopa County to a period of involuntary inpatient treatment to be administered by Defendant Comcare for a minimum period of 25 days and continuing thereafter, ". . . until subsequent order of the court".

XVII.

Contrary to the clear indications of his continuing mental health deterioration and contrary to the clear evidence that Matthew Brower was an imminent danger to do physical harm to himself and to others, and contrary to the specific order of the court that he be committed for a period of at least 25 days and thereafter ". . . until further order of the court", on March 24, 1998, the Defendants discharged Matthew from inpatient care at Desert Samaritan Hospital and immediately thereafter released him from any and all inpatient treatment and returned him to Marilyn Brower's home.

XVIII.

Under Arizona law, specifically Arizona Revised Statutes §36-541.01(A), Matthew J. Brower's release from involuntary inpatient care without court order could only be accomplished upon "the opinion of the medical director of the mental health treatment agency" that the patient "no longer is, as a result of a mental disorder, a danger to others, a danger to self, persistently or acutely disabled or gravely disabled." However, decedent Marilyn Joann Ulrich Brower was advised that Matthew's release from defendants' care and inpatient treatment was due to a shortage of inpatient treatment space, and that he would have to return home, over her objection, ". . .or be put out in the street". Notwithstanding Mrs. Brower's fears and concerns, COMCARE officials pleaded with her to take her son while they searched for a space, assuring her that he was not a danger to her.

XIX.

At the time of his release from Defendants' inpatient care, Matthew J. Brower returned to the home he shared with decedent Marilyn Brower, against whom he was known to have made regular and repeated threats, on the Defendants' assurance that Matthew J. Brower was not a danger. Matthew J. Brower was prescribed a course of medication, which was to be administered twice daily under the direction and supervision of Defendant COMCARE and/or its agents, META, and was visited and assisted by a COMCARE caseworker, and a META worker who was to administer the medication.

XX.

On the evening before the shootings, Marilyn Brower advised Matthew's COMCARE caseworker that Matthew was recalcitrant and becoming "aggravated" at her. The caseworker merely advised Mrs. Brower that she was investigating yet another treatment program that might accept Matthew and hoped to place him as soon as possible.

XXI.

Autopsy results on the body of Matthew Brower following his self-inflicted shooting death show that Defendants COMCARE and META, in breach of their duties to Matthew and to Marilyn Brower, did not ensure that Matthew took his medication or refrain from other physically deleterious behaviors such as the consumption of alcohol while awaiting placement.

XXII.

Defendants State of Arizona, COMCARE, META and each of them, were at all times material hereto required by Arizona statutory and common law, by court order, and/or by contractual agreements by and between Defendants, to provide competent and adequate mental health and behavioral care and treatment to Matthew J. Brower and persons similarly situated. These duties were non-delegable in all respects, and constituted a joint venture and/or action in concert to provide such care. The breach of such duties by Defendants, separately or jointly, renders all Defendants jointly and severally liable to the Plaintiffs for their injuries and damages.

XXIII.

At the time of the events complained of, Defendants COMCARE and META were behavioral mental health providers licensed by Defendants State of Arizona, and under contract with Defendant State of Arizona to provide behavioral and mental health care services, on behalf of Defendant State of Arizona, either directly or by sub-contract with direct service providers, in a region including Maricopa County.

XXIV.

Specifically, decedent Matthew J. Brower came into the care of Defendants the State of Arizona, COMCARE and META for involuntary mental health and behavioral care and treatment on or about January 29, 1998, when he was petitioned and placed for involuntary mental health treatment by the State of Arizona. At that time, COMCARE and META were licensed, under contract, employed and/or operated by the State of Arizona, to provide state-mandated, state-or-federally-funded, and/or state-or-federally-subsidized mental health services, including services to the seriously mentally ill and general mental health services, in and for the County of Maricopa, either directly or by sub-contract with direct providers.

XXV.

Indeed, during the period of decedent Matthew Brower's involuntary care and treatment commencing January 29, 1998, Defendant COMCARE was being operated under the direct authority, control and management of the State of Arizona, its officers, servants, employees and agents, pursuant to Arizona Revised

Statutes §36-3412(D).

XXVI.

Prior to and after Matthew Brower came under the care of COMCARE on January 29, 1998, Defendants, their agents and/or employees knew or should have known that Defendant COMCARE was inadequately staffed, had poorly trained personnel, was improperly managed and/or directed and/or administered, had failed to comply with its contractual and statutory requirements, had failed to take all necessary and corrective actions despite having been ordered to do so, and generally, thoroughly and repeatedly failed to provide Matthew Brower and others similarly situated with competent and adequate mental health and behavioral care and treatment as required by Arizona statutory and common law; failed to properly inspect and monitor COMCARE, failed to insist that all corrective actions be taken so as to provide the necessary, competent and adequate mental health and behavioral care required by Arizona statute and law; grossly failed to insist that COMCARE fully comply with its contractual obligations; grossly failed to insist that COMCARE take full and complete corrective actions and become adequately staffed, trained and funded; and failing that, grossly failed to stop placing patients under the care of COMCARE and thereafter grossly failed to revoke COMCARE's operating license.

XXVII.

With respect to the treatment afforded decedent Matthew Brower, Defendants, and each of them, were further and specifically negligent in that:

(a). Between January 29, 1998 and March 31, 1998, Defendants State of Arizona, COMCARE and META negligently failed to prepare, approve, and/or implement an adequate mental health treatment plan for Matthew Brower.

(b). Between January 29, 1998 and March 19, 1998, while Matthew Brower remained in inpatient care and treatment, Defendants negligently failed to administer to and treat Matthew Brower in order to control or prevent the type of violent, aggressive and threatening behavior against himself and others of which they knew or should have known him capable, and in fact rendered no treatment to Matthew Brower that would control or prevent violent, aggressive and threatening behavior against himself and others, so as to render him no longer a danger to himself and others.

(c). On or about March 24, 1998, Defendants negligently released Matthew Brower from court-ordered inpatient mental health care and treatment and sent him home to his mother, notwithstanding unanimous medical evaluations concluding that Matthew Brower was a serious danger to himself and others, acutely, gravely and persistently disabled and likely to inflict serious harm, and that his mother was the subject of his anger, hostility and threats.

(d). In releasing Matthew Brower from court-ordered inpatient mental health care and treatment, Defendants negligently failed to adequately diagnose the mental condition of Matthew Brower, and/or to make reasonable and requisite findings that Matthew Brower was no longer, as a result of mental disorder, a

danger to himself or others or persistently, acutely or gravely disabled.

(e). In releasing Matthew Brower from court-ordered inpatient mental health care and treatment, Defendants negligently failed to ascertain and consider the entire past history of Matthew Brower, the violent and aggressive conduct in which he had previously engaged, the repeated threats voiced against himself and others, specifically targeting decedent Marilyn Brower, the lack of progress in treatment and the psychological deterioration which Matthew Brower was evidencing, in arriving at their conclusion regarding the kind of treatment he needed and the type of security he required.

(f). In releasing Matthew Brower from court-ordered inpatient mental health care and treatment, said Defendants negligently, recklessly, willfully and wantonly permitted considerations of space and cost to override medical considerations regarding Matthew Brower's medical conditions, treatment needs, and persisting danger to himself and others.

(g). In releasing Matthew Brower from court-ordered inpatient mental health care and treatment, Defendants negligently failed to adequately and properly advise its agents or employees engaged in outpatient care of Matthew Brower, and/or Matthew's mother, housemate and foreseeable caregiver decedent Marilyn Brower, of Matthew Brower's medical conditions, treatment needs, and persisting danger to himself and others; and/or negligently failed to advise such agents and employees, and/or decedent Marilyn Brower, of signs and symptoms of deterioration in Matthew

Brower's mental state, and/or appropriate procedures for monitoring or reporting such signs and symptoms to Defendants or other authorities in order to minimize reasonably foreseeable risk of Matthew Brower's danger to himself and others;

(h). Upon the discharge and release of Matthew Brower from court-ordered inpatient mental health care and treatment, between March 24, 1998 and March 31, 1998, Defendants negligently failed to provide adequate treatment, supervision, and/or monitoring for Matthew Brower, notwithstanding their knowledge or constructive notice that Matthew Brower was a danger to himself and others and that his mother was the subject of his anger, hostility and threats.

(i). Upon the discharge and release of Matthew Brower from court-ordered inpatient mental health care and treatment, between March 24, 1998 and March 31, 1998, Defendants negligently failed to ensure that Matthew Brower was taking his prescribed medication, notwithstanding their knowledge or constructive knowledge that Matthew Brower had a history of refusing medication upon release from inpatient care.

(j). Defendants negligently failed to comply with statutory and regulatory mandates regarding the rendition and termination of care for the seriously mentally ill pursuant to Arizona Revised Statutes §36-3431 et seq.

(k). Defendants negligently failed to maintain the standard of professional care required of them in the provision of mental health services and the diagnosis, treatment, observation, care and control of the mentally ill under Arizona law, and their

conduct fell below the standards of care for others in the Defendants' professions.

(l). At all material times, Defendants negligently hired, trained and/or supervised their agents, employees, and subcontractors, such that said agents, employees and subcontractors failed to provide competent and adequate mental health and behavioral evaluation, care, treatment, supervision and monitoring to Matthew Brower.

XXVIII.

The negligence of Defendants directly and proximately caused or contributed to the wrongful deaths of decedents Marilyn Brower and Matthew Brower.

XXIX.

As a direct and proximate result of the conduct of the Defendants, Marilyn Brower's children and mother have lost Marilyn Brower's love, society, companionship, comfort, advice, care and protection, and have suffered and will suffer economic damages, including loss of support and have incurred medical, funeral and burial expenses.

XXX.

Defendants were negligent, grossly negligent, and were acting with a reckless indifference and a willful disregard for the rights of Marilyn Brower and Matthew Brower in that they failed to fulfill the duties and obligations they owed to Marilyn Brower and Matthew Brower. The conduct of the Defendants was such that it demonstrated an evil mind to such an extent that an award of punitive and exemplary damages is appropriate, to the fullest

extent they can be appropriately awarded, to punish the Defendants for their conduct and to make an example of them so that no other person or entity like the defendants will act in the same manner in the future.

XXXI.

Plaintiffs did submit timely notices of their claims to the Defendant State of Arizona, which have, by passage of time and by inaction of the Defendant State of Arizona, been denied.

COUNT TWO
VIOLATION OF RIGHTS OF DECEDENTS MARILYN BROWER AND MATTHEW BROWER UNDER 42 U.S.C. §1983 BY DEFENDANTS STATE OF ARIZONA, META SERVICES, INC. AND COMCARE

XXXII.

Plaintiffs reallege paragraphs I. through XXIX. above.

XXXIII.

Defendants State of Arizona, COMCARE, and META and each of them, acted jointly under color of state law with the State, its agencies, agents and employees and through a close nexus with the State, its agencies, agents and employees in providing mental health and behavioral care and treatment to Matthew Brower and others similarly situated.

XXXIV.

By failing to provide adequate and competent care and treatment to Matthew Brower, Defendants, and each of them, caused Marilyn Brower and Matthew Brower to be deprived of their rights, privileges, and immunities secured by the Constitution of the United States by depriving them of their privacy and security as persons, by inflicting cruel and unusual punishment upon them as individuals, by depriving them of life and liberty without due

process of law, and by violating their rights to equal protection under the law.

XXXV.

Through gross negligence and/or recklessness, Defendants and their agents and employees violated Marilyn Brower's and Matthew Brower's constitutional rights including, but not limited to, their right to privacy and security, their right to be free from cruel and unusual punishment, their life and liberty interests, and their right to equal protection of the laws.

XXXVI.

Under the circumstances, Defendants State of Arizona, COMCARE, META, their employees and agents, and each of them, are liable for their conduct in authorizing, licensing, contracting with, and/or operating COMCARE when they knew or should have known their acts and omissions would inflict the constitutional injuries described herein.

XXXVII.

As a direct and proximate result of the acts and omissions of Defendants, decedents Marilyn Brower and Matthew Brower suffered abuse, neglect, pain, suffering and death, unequal and discriminatory treatment and punishment, loss of life and liberty, loss of enjoyment of life, funeral expenses and loss of earning capacity in an amount to be proven at trial in excess of the jurisdictional limit of this Court.

XXXVIII.

Defendants' acts and omissions constitute reckless indifference and/or conscious disregard for Marilyn Brower's and

Matthew Brower's life, health, safety, and welfare, and Plaintiffs are therefore entitled to punitive damages, in an amount to be determined at trial.

XXXIX.

Plaintiffs are further entitled to the costs of suit herein, including reasonable attorneys' fees, pursuant to 412 U.S.C. §1983 et seq.

COUNT THREE
VIOLATION OF ARIZONA REVISED STATUTE §46-455
BY DEFENDANTS STATE OF ARIZONA, META and COMCARE
ON BEHALF OF MATTHEW BROWER

XL.

Plaintiff realleges paragraphs I. through XXXVII. above.

XLI.

Defendants State of Arizona, META and COMCARE, and each of them, violated Arizona statutory law prohibiting the abuse and/or neglect of incapacitated or vulnerable adults.

XLII.

Decedent Matthew Brower, during the period January 29, 1993 through March 31, 1998, was an incapacitated and/or vulnerable adult due to impairment by reason of mental illness and/or mental disorder or other causes to the extent Matthew Brower lacked sufficient understanding or capacity to make or communicate informed decisions regarding his person or to protect himself from abuse, neglect or exploitation by others.

XLIII.

Defendants State of Arizona, META and COMCARE, by the negligent acts and omissions, misdiagnosis, precipitous release and deprivation of treatment and services needed to maintain

minimum mental health and life as set forth hereinabove, abused and neglected Matthew Brower in or about the period from January 29, 1998 through March 31, 1998.

XLIV.

The conduct of Defendants in neglecting and abusing decedent Matthew Brower, in misdiagnosing Matthew Brower, precipitously releasing him from care, and depriving him of treatment and services necessary to maintain minimum mental health and life was outrageous, grossly negligent, reckless and in reckless and wanton disregard of their statutory duties toward Matthew Brower.

XLV.

As a direct and proximate result of said Defendants' abuse and neglect of Matthew Brower, said Defendants are liable for the payment of actual and consequential damages, as well as punitive damages, costs of suit and reasonable attorneys' fees, pursuant to Arizona Revised Statutes §46-455.

COUNT FOUR
CLAIMS AGAINST K MART

XLVI.

Defendant K Mart is and was at all times material hereto authorized to and does regularly advertise and sell firearms and ammunition in its stores in Maricopa County, Arizona.

XLVII.

On or about March 27, 1999, Matthew Brower purchased a Mossberg shotgun and ammunition from Defendant K Mart.

XLVIII.

At the time of the purchase Matthew was a "prohibited possessor" of the shotgun pursuant to ARS § 13-3106(6).

XLIX.

Defendant K Mart and its agents and employees knew or should have known that Matthew Brower was a "prohibited possessor" of the shotgun, and should not have sold it to him.

XLX.

Defendant and its agents and employees, in selling the shotgun to Matthew, acted in violation of ARS §13-3102(A)(5) and were negligent in selling the shotgun to Matthew Brower, and their conduct was negligence per se.

XLXI.

The sale of the shotgun to Matthew Brower by Defendant K Mart and its agents and employees was in violation of the Federal Gun Control Act, 18 U.S.C. §922 and their conduct was negligence per se pursuant to that act.

XLXII.

At the time the Defendant K Mart and its agents and employees sold the shotgun to Matthew Brower they knew, should have known and in the exercise of reasonable due care would have known that Matthew Brower had a mental disease or disorder rendering the sale to him of a shotgun inherently dangerous and hazardous so as to place his life and the lives of others in immediate risk.

XLXIII.

The death of Marilyn Brower and the death of Matthew Brower were both as direct and proximate result of the carelessness, recklessness, and negligence of the Defendant K Mart and its agents and employees.

WHEREFORE, Plaintiffs demand judgment against Defendant for all their general and special damages incurred herein, including but not limited to the following: for Plaintiff Estate of Marilyn Brower, Deceased, and for the Statutory Claimants, Theodore Joseph Brower, Dawn Marie Alexander, Michelle Ann Canter, Valerie Theresa Alfonso and Helen Neimas damages for the loss of love, affection, companionship, care, protection and guidance since the death of Marilyn Brower and in the future; for the pain, grief, sorrow, anguish, stress, shock, and mental suffering, already experienced and reasonably probable to be experienced in the future; for the income and services that have already been lost as a result of the death and that are reasonably probable to be lost in the future; for the reasonable expenses of funeral and burial; for punitive and exemplary damages in an amount sufficient to punish the Defendants for their conduct and to make an example of them so as to prohibit others from acting as these Defendants did in the future; for the Estate of Matthew J. Brower, Deceased, for the income and services that have been lost as a result of the death and are reasonably probable to be lost in the future; For the reasonable expenses for funeral and burial; for damages for the conscious pain and suffering incurred by Matthew Brower after the date of the Defendants' conduct resulting in his death and the date and time of his death; for Plaintiffs' reasonable attorneys'

fees incurred so as to defray the costs of this litigation all as authorized by Federal and State statute; for Plaintiffs' costs incurred herein; for interest on the judgment for any of the special damages proven by the Plaintiffs at the maximum rate allowed by law from the date each item of special damages was incurred until paid; for interest on the judgment for Plaintiffs' general damages at the maximum rate allowed by law from the date of the jury verdict until paid; for interest on judgment for punitive and exemplary damages at the maximum rate allowed by law from the date of verdict until paid; for interest on the judgment for costs at the maximum rate allowed by law from the date each item of cost was incurred or from the date of judgment, whichever the Court deems appropriate, until paid; for such other and further relief as the court deems just and proper.

Dated this 24th day of March, 1999

BEGAM, LEWIS, MARKS & WOLFE, P.A.

BY _____
Steven M. Friedman
Lisa Kurtz
111 West Monroe Street
Suite 1400
Phoenix, Arizona 85003
Attorneys only for Plaintiff,
DENISE ACKERMAN, as personal
representative for the
statutory beneficiaries of
the Estate of Marilyn Joann
Ulrich Brower

and

ANDERSON, HURWITZ & HARWARD, P.C.

BY _____
Randy J. Hurwitz
6390 E. Thomas Road
Suite 320
Scottsdale, Arizona 85251
Attorneys only for Plaintiff,
EDWARD GAUDREAU, as personal
Representative of the
Estate of Matthew J. Brower

BEGAM LEWIS MARKS & WOLFE
A PROFESSIONAL ASSOCIATION OF LAWYERS

40286